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Chemist&Druggist
The Newsweekly for Pharmacy

3 September 2005

Wales consults on control of entry reforms

Tighter controls needed for illicit web pharmacies

How the NHS wants you to show leadership

Deadline draws near – are you ready for Oct 1?

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- TENA accounts for two-thirds of UK retail sales of incontinence products[1]
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- The UK's ageing population means exceptional growth potential for TENA *Pants*.

[1] Source: IRI 52 w/e 14 May 2005 Total Market Volume Share
[2] Source: IRI 52 w/e 14 May 2005 Total Market Value Share
[3] Source: SCA market potential calculations 2005

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TENA *Pants* Discreet

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TENA

TENA *Pants* PRODUCT RANGE

Product	Size	Pip code	Box contents
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TENA *Pants* Discreet	L	283-2343	4 x 10 (40)
TENA *Pants* Plus	XS	293-6425	4 x 11 (44)
TENA *Pants* Plus	†S	220-9864	4 x 14 (56)
TENA *Pants* Plus	M	220-9872	4 x 10 (40)
TENA *Pants* Plus	L	220-9880	4 x 8 (32)
TENA *Pants* Super	M	296-6273	4 x 12 (48)
TENA *Pants* Super	L	296-6281	4 x 12 (48)

† Product suitable for older children/small adults.
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Contents

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C&D

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Welsh entry proposals tighten up 'loophole'

Welsh doctors applying to dispense in rural areas will face tougher rules under new proposals to reform the control of entry regulations in Wales.

The proposals come in a new Welsh Assembly consultation, *Proposal to reform the NHS (Pharmaceutical Services) regulations 1992: SI 662*.

The over-riding aim of the document is to make the system for hearing pharmaceutical services applications and appeals processes more business-friendly, more certain, reliable and less time-consuming. Stakeholders have been invited to comment on several elements of the pharmaceutical services application process. These include:

- Determining the adequacy of pharmaceutical services provision.
- Simplifying the decision-making process.
- The range of consultation.
- Minor relocations.
- Cross-local health board boundary minor relocations.
- Granting preliminary and full consent.
- Introducing a requirement to commence services.
- Facilitating the appeals process.
- Revising the current application form.

The document also highlights dispensing doctor applications as an area in particular need of reform. Accepting that there is a current "disparity" in the tests applied to pharmacists and doctors wishing to dispense in controlled areas, the Welsh Assembly says it wishes to remove any criteria disparity between similar types of application.

For Llandysul pharmacist Richard Evans, the news of the reforms has come too late; his businesses are currently facing three applications from doctors wanting to dispense in his area. Describing these as "a serious threat to his business", he is expecting a decision on one of the applications within the next three to four weeks. He does, however, welcome the Welsh Assembly initiative to bring Welsh rural dispensing legislation further in line with the rules on rural dispensing in England, which were amended in April.

The Dispensing Doctors Association (DDA) estimates that there are about 330 dispensing doctors in Wales, serving a patient dispensing list of around 188,000. DDA chairman Dr Malcolm Ward says that the DDA supports the move to bring Wales into line with England.

The Welsh consultation follows the January 2003 Office of Fair Trading (OFT) report *The Control of Entry Regulations and Retail Pharmacy Services in the UK*, which was rejected by the Welsh Assembly because of concern over the impact of the report's recommendations on small pharmacies, particularly in socially disadvantaged and rural parts of Wales.

The Welsh Assembly says that the aim of the new consultation is to arrive at a balanced package of measures that will continue to raise standards for patients, support the needs of small businesses, and do so without jeopardising the vital role played by community pharmacies, particularly in poorer and rural areas.

The consultation is open until November 14. **AC**

For more information :

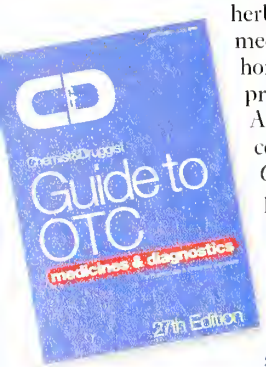
E-mail: *Mark.Welsby@Wales.gsi.gov.uk*

C&D

27th Guide to OTC Medicines published

The 27th edition of the *Chemist & Druggist Guide to OTC Medicines and Diagnostics* is published with this week's issue of *C&D*.

Updated twice a year, the *Guide* is a listing by therapeutic category of branded OTC medicines, herbal medicines, and homoeopathic preparations.



Additional copies of the *Guide* may be purchased, priced £10 for subscribers and £15 for non-subscribers.

Cheques made payable to CMP Information Ltd, should be sent to *C&D*, Sovereign House, Sovereign Way, Tonbridge, Kent TN9 1RW. Orders can also be made with a credit card.

For further information contact Jan Powis on 01732 377487 or *jpowis@cmpinformation.com*.

RETAILING

Wood reassures Numark members

Numark chief executive David Wood has reassured members that the organisation will continue to champion the interests of independent pharmacy in the event of a takeover by wholesaler Phoenix.

Keeping members happy would be vital to the future success of the Tamworth-based organisation should shareholders accept a £27.2 million cash offer from Phoenix, said Mr Wood.

"As soon as you stop doing what your members want then you will stop being successful," he stressed.

The comments came in response to concerns voiced by Numark members that a merger with wholesaler Phoenix could result in a damaging loss of independence for the symbol group (*C&D, August 27, p3*).

However, Mr Wood predicted a buoyant future for Numark with Phoenix at the helm. "I don't think members need to worry over the effects of the acquisition

because Phoenix have outlined their plans to run Numark as a separate company.

"This organisation has not been an Industrial and Provident Society since 2002 and we've enjoyed record-breaking success and member satisfaction since then." **MG**

RPSGB

Society warns of over-regulation

The RPSGB has warned that community pharmacists are having to cope with increasing amounts of regulation.

In its response to the Government's review of non-medical professional regulation (known as the *Foster Review*), the Society points out that while the Government is seeking to reduce unnecessary regulation in the public and private sectors, the *Shipman Inquiry* has recommended a number of measures that would create "substantial increases" in regulatory activity.

"There is something of a gap between Government aspirations to reduce unnecessary regulation and the experience of those at the frontline," the response says. "Our independent contractor Council members have told us that for community pharmacists there is an increasing burden of regulation, particularly in relation to the clinical governance requirements of the new contract."

The Society's response to the review is available at *www.rpsgb.org/policy* or by contacting Karen Turnham on 020 7575 2218. **CRG**

Fancy a cruise down the Amazon? Charity [illegible] pharmacist to help with its mission to [illegible] dental care and [illegible] pharmacy equipped with over 35 [illegible] accounting to [illegible] learned in a retail environment to help [illegible] out more information [illegible]

ONLINE

Report calls for clampdown on illegal e-pharmacies

by Max Gosney

Tougher measures are needed to prevent the supply of dangerous drugs via illegal internet pharmacies, a new report has warned.

Current regulations fail to stop illegitimate web-based operators cashing in on Prescription Only Medicines including heroin substitutes and antidepressants, according to an investigation by independent think-tank, the Centre for Reform.

The report, which was part-funded by pharmaceutical manufacturer Merck Sharp & Dohme, called for harsher sentences for those found guilty of illegally supplying drugs online and greater Government investment to help police the web.

The introduction of a logo to determine legitimate web pharmacies or a register of certified operators would boost customer safety, claimed the report, *Online Pharmacy: Patient Choice or Patient Peril*.

However, specific criminal offences relating to online pharmacy fraud, a public health campaign and an international task force could also be necessary measures to successfully combat pharmacy web abuse, said the authors. These include Dr Julian Harrison, commercial director at internet pharmacy firm Pharmacy 2U.

Legitimate e-pharmacy firms were backed by the report as "registered and regulated". But online operators must look to counter a lack of "face-to-face" contact with patients via their service, says the report.

Simon Williams, director of policy at the Patients' Association, backed the report findings. He said: "If people do not have a simple and quick way of being able to check if an online pharmacy is legitimate, they will simply not check before ordering and will be putting their health at risk. Regulators must address this matter now."

Internet crackdown

Key recommendations to prevent the spread of rogue internet pharmacies according to the report:

- Logo for legitimate internet pharmacies.
- Greater government resources dedicated to policing the web.
- Introduction of criminal offences specifically relating to internet pharmacy fraud.
- Tougher sentences for those found guilty of operating illegal web-based pharmacies.
- International task force to help regulate the internet.
- Public health programme to warn people about the risks of illegitimate internet pharmacy.

In brief

Lipitor recall

The Medicines and Healthcare Products Regulatory Agency has issued a Class 3 recall for Lipitor 10mg tablets (atorvastatin calcium).

Bearing the batch number 0533094G and expiry date 08/2007, blister strips of the affected stock have been incorrectly over-labelled as Lipitor 20mg tablets. Pharmacists should quarantine any remaining stock and return it to their supplier for credit. For more information, contact Lexon (UK) returns department on 0800 138 2293.

Prince of Wales orders CAM report

The Prince of Wales has commissioned an independent report on the benefits of complementary therapies, which will be published later this year.

A Clarence House spokeswoman confirmed a report in *The Times* newspaper that Sir Christopher Smallwood, an independent economist, is leading on the paper which will consider the cost-effectiveness of an integrated healthcare system. Gemma Smith said the Prince had ordered the report as a result of his longstanding interest in complementary and alternative medicines and therapies.

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in August:

- Indigestion part 2 (1345)
- Renal 4 – drug precautions (1346)
- Thrush (1347).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on *www.dotpharmacy.com*.

Further information is available from Mary Prebble on 01732 377269. Genus Pharmaceuticals supports the MCQ and telephone marking service.

Newsdesk 01732 377688

Online pharmacy support suite launched

A London pharmacist is launching an online suite to help independent contractors meet clinical governance, medicines use review and standard operating procedure requirements.

As reports can be sent electronically to primary care organisations, the system should also ensure the pharmacy receives payment for complying with the pharmacy contract.

Pritpal Thind's system provides templates that can be tailored to individual pharmacies' needs, while also providing a customer-facing site. On the public side, patients can request prescriptions, print information leaflets and the pharmacy can offer product sales online. The site incorporates firewalls for data safety.

Mr Thind, from Shepherd's Bush, has spent five years developing the system to help him with his own business, Caregrange Pharmacy. As testing of the system is nearing completion, he is now looking to licence it out to help other independent pharmacies improve their business. He is also seeking accreditation from the Department of Health for electronic transfer of prescriptions.

Among the facilities that the system offers are:

- A 'front end' web presence for marketing the pharmacy to the public (*www.firstpharmacy.co.uk* is an example of how the site appears on the internet).
- SOP templates: the module allows the pharmacist to set up procedures, update existing ones and to allocate steps or processes in the procedure, to named members of staff.
- Clinical governance: for waste records, fridge temperature recording (with a prompting system), product alert records and adverse event recording, which can be sent direct to the PCT.
- MUR: this should speed up the process, and allows the pharmacist to print off the recommendations for the patient and send to the GP.

Other modules in development include smoking cessation, emergency contraception, *H pylori* testing and diabetes services.

"It's an easy method of keeping SOPs up to date," Mr Thind told *C&D*. "As the pharmacy modules start to develop, eg for nursing homes or delivery by mail, we can add new procedures very easily."

Mr Thind believes pharmacists, especially those with low prescription numbers, can use the online suite to generate new customer interest, without necessarily increasing footfall, as patients can register online for repeat prescriptions.

Having a second computer terminal on the shop floor is also boosting customer interest in the pharmacy. He says that in the four months that he has been using his system, his prescription numbers have increased by over 25 per cent.

The system can be accessed entirely online, and is straightforward to use, so Mr Thind says there is no need for a site training visit. Pharmacists may need to spend a day setting up the SOPs specific to their pharmacy, but once entered, data can be updated very easily. All changes are logged, making audit easier.

Mr Thind will charge £599 to set up the site for the first pharmacy address per customer, and £499 for each additional site up to 10 pharmacies. There will be a monthly charge of £25 for hosting and updating the sites.

Mr Thind can be contacted at his pharmacy on 020 8746 0773 or on: *pritpalcz@hotmail.com*.

Orders placed by September 20 should mean the site is ready for October 1. **CRG**

EDUCATION

Keele to open School of Pharmacy

A new School of Pharmacy is due to open at Keele University next year, subject to accreditation by the Royal Pharmaceutical Society.

The SoP will complement the Staffordshire institute's existing pharmacy postgraduate offering.

Steve Chapman, professor of prescribing studies and head of Keele's medicines management department, has been named SoP head and Mark Brennan, a community pharmacist and law and ethics specialist who is currently undertaking work at Aston University, will be director of undergraduate studies. A full complement of staff will be recruited over the next three years.

Keele is working closely with the RPSGB to ensure it meets the full requirements for accreditation, said Professor Chapman. If approved, the SoP hopes to start 40 undergraduates on the new four-year MPharm course in September 2006 and accept a maximum of 80 students per year thereafter.

Steve Chapman: students will be taught to integrate science and practice

Both community and hospital pharmacies in the region had experienced problems recruiting pharmacists, so were hoping Keele graduates would remain in the area after qualifying, he added.

Describing the course as "experiential", Professor Chapman explained: "We are looking at establishing a 'professional spine' so, right from the start of the course, students will be taught to integrate science and practice."

With the aim of delivering a patient-focused course, the School is working with expert patients to develop a "patients as teachers" initiative, he said, adding that undergraduates would also benefit from interdisciplinary learning with other health students, placements with local pharmacies, and problem based learning. **AF**

MULTIPLES

Boots staff make a stand over new tills

Boots's decision to introduce standing-only tills at some stores is illegal and could leave staff with health problems, the union for shop workers has warned.

Failing to offer checkout workers seating at stores in Manchester and the Midlands represented a breach of health and safety regulations, according to the Union of Shop, Distributive & Allied Workers (USDAW).

Doug Russell, health and safety officer at USDAW, said: "We take the view that Boots is breaking the law by introducing these tills."

However, Boots refused to discard plans for further standing-only tills. It stressed it was working with USDAW to resolve the opposition.

PATIENTS

Epilepsy campaign

A campaign urging patients with epilepsy to take control of their condition has been launched through pharmacies.

Organised by the charity Epilepsy Action, the Take Control initiative aims to help those with epilepsy understand their symptoms, treatment, side effects, and highlight the support, resources and services available.

Although Epilepsy Action hopes to roll out the scheme nationally, pharmacies can get involved earlier by contacting Ian Turnpenny on 0113 210 8800.

Questiontime

This week's question:

Who should be responsible for enforcing online pharmacy standards in the UK?

- **MHRA**
- **RPSGB/PSNI**
- **Police**
- **An unknown specialist internet regulator**

You have until noon on September 6 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on September 10.

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SCOTLAND

Scotland to input on NICE appraisals process

England and Wales could soon be using Scottish decisions on new drugs as a way of speeding up their appraisals system.

Currently the National Institute for Clinical Excellence assesses new drugs in England and Wales and conducts a long, in-depth assessment of medicines. In Scotland, however, the Scottish Medical Consortium conducts rapid appraisals of medicines as soon as possible after they are launched. Typically, NICE appraises medicines approximately 18 months after SMC has considered them and its decision takes precedence since it will usually be informed by more evidence on clinical effectiveness.

According to a Department of Health spokesman, ministers acknowledge that the time-lag between the two systems does cause issues for English and Welsh patients, who may be unable to access a drug that is already available in Scotland. The DoH confirmed that it would be looking to assess the current set-up in England and Wales over the next few weeks. One plan already mooted is that assessments made by the SMC could be used in England as a 'stop-gap' until the NICE assessment is available. **AC**

INDUSTRY

Merck criticised over Vioxx settlement bias

Legal experts have slammed Merck over its decision to favour settlement of Vioxx lawsuits with claimants who used the drug for over 18 months.

The pharmaceutical firm's policy was unsatisfactory and unfair said Dr Sarah Richards, a solicitor at Hugh James Solicitors in Cardiff. The harm caused to patients using Vioxx could not be assessed in the time period they took the medication, warned Dr Richards, who is helping over 100 people launch legal action against Merck in the USA (*C&D, August 27, p6*).

"There are many people who took Vioxx for less than 18 months who have suffered equally to those who took the drug for longer. I don't think it's a fair assessment of how the drug affected each user," she said.

The criticism comes after Merck made a U-turn on its legal tactics after the award of $253 million damages against the company by a Texas jury last month.

Merck said it would consider settling some Vioxx lawsuits rather than contest all of the estimated 2,100 claims as it originally stated. The company ruled out a global settlement and said it would focus on cases that involved patients who used Vioxx for over 18 months and had no other risk factors. **MG**

PR

NPA shows the friendly face of pharmacy

The National Pharmacy Association is spending £250,000 to launch its "developed and revitalised" *Ask Your Pharmacist* media campaign.

Using the NPA's new corporate identity unveiled in July (*C&D, July 9, p4*), five ads are making their debut in the women's press this month.

Titles such as *Top Sante, Now, Mother & Baby, New Woman, Yours, Health Plus, Pregnancy & Birth* and *Woman's Own* will carry the advertisements, which according to the NPA, focus on lifestyle rather than ailment and cure. The aim is to raise awareness of the skills of the community pharmacist and the changing face of pharmacy under the new contract and create increased consumer demand for the expanding range of community pharmacy services available.

Aspirational imagery of healthy, calm and relaxed people is used in the ads to reinforce 'the fresh and friendly face of pharmacy' strapline, together with easy-to-understand supportive text. **JE**

PAEDIATRICS

Use of P for paediatric medicines would be confusing, says RPSGB

The RPSGB is against using 'P' as a way of identifying paediatric medicines owing to the confusion it would create with the Pharmacy Only class of medicines.

The RPSGB was responding to the MHRA's *Consultation on the European Commission's proposal for a regulation of the European Parliament and of the Council on Medicinal Products for Paediatric Use*, which aims to improve the health of the European paediatric population by increasing the research, development and authorisation of medicines for use in children.

In the Society's response to the proposals, Sue Kilby, head of practice, said it would like the paediatric committee within the European Medicines Agency (EMEA) to include someone with expertise in pharmacy.

The Society also strongly supports maintaining availability of paediatric medicines on the market and says that pharmaceutical companies should provide notice of discontinuation or transfer of a product. The notice time period should, wherever possible, be of a reasonable length.

"The impact of discontinuation of products should not be underestimated," said the Society.

The Society also agrees that parts of the paediatric clinical trials database should be accessible to the public in the interest of transparency. It should particularly be available to healthcare professionals and researchers involved in paediatric medicines research. **JE**

SURVEY

Britons do not consult over pain relief, study finds

More than half of headache sufferers (57 per cent) take tablets that are not the most effective for their symptoms. And less than 30 per cent of people suffering from painful muscle cramps are treating their condition effectively.

These are two of the findings of a survey conducted by YouGov for Lloydspharmacy, which questioned 1,980 UK adults online from March 1-3, 2005 and published the results last week.

Only 21 per cent of those questioned are taking a pain relief product on the recommendation of a doctor and only 37 per cent have ever consulted a pharmacist, yet more than 80 per cent believe they are using the correct product for the pain they are suffering.

Backache is the biggest problem affecting 55 per cent of Britons, followed by joint pain or inflammation (41 per cent) and tension headaches (28 per cent).

More women than men suffer from tension headaches and twice as many have migraines.

The main cause of headaches, finds the survey, is lack of sleep (mentioned by 53 per cent), with 48 per cent of men citing work stress and 41 per cent of women blaming stress at home.

Chris Frost, head of medicines at Lloydspharmacy, said: "Some pain relief products are more effective than others in treating specific symptoms. Also, some products are not suitable for certain people – so it's vital to speak to a pharmacist or other medical expert for advice."

Lloydspharmacy has recategorised painkillers as a result. **JE**

GOING FOR GOLD

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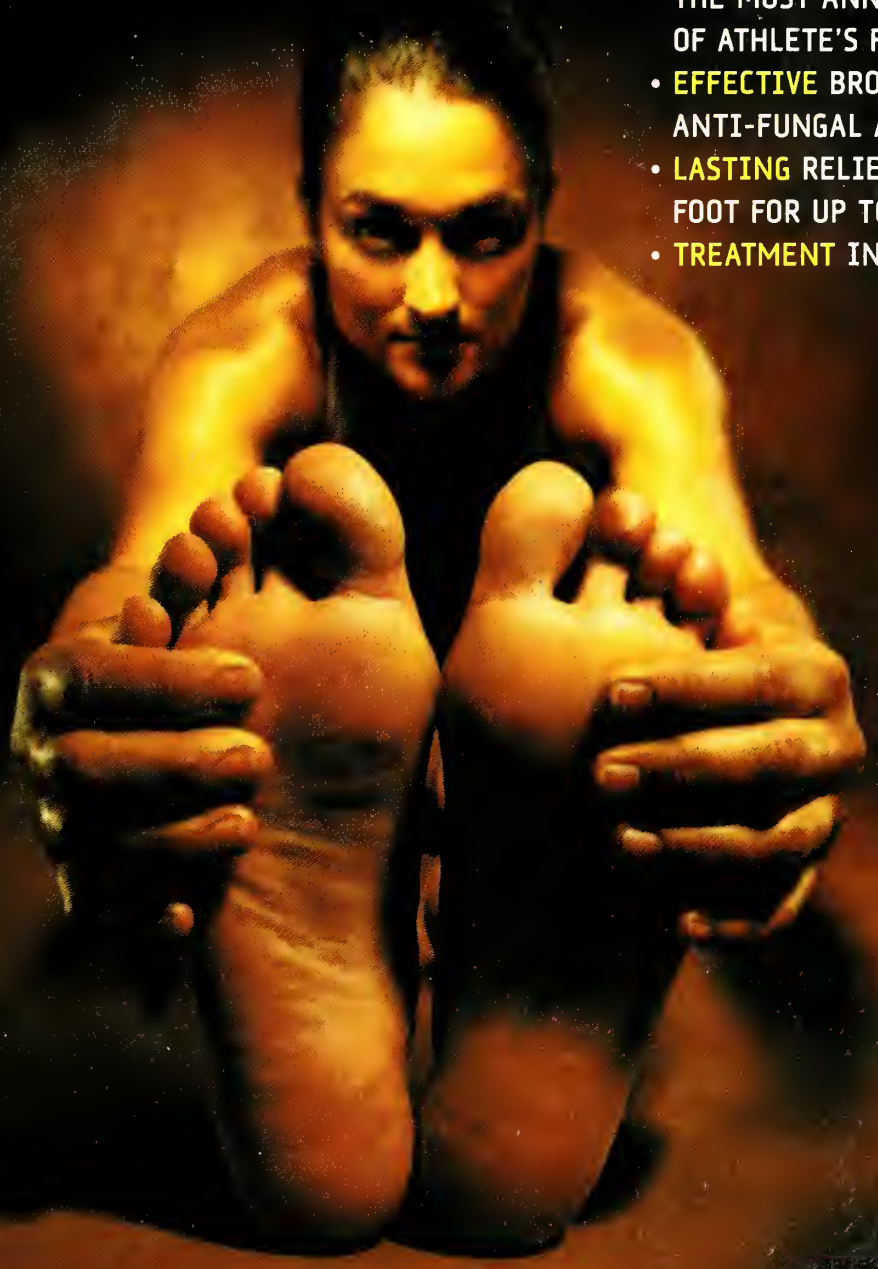
- TREATMENT IN JUST ONE WEEK*



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*Relates to mild athlete's foot, in most cases
**Based on IRI sales data 52 w/e 16 April 05

Product Name: Daktarin Gold. **Presentation:** Cream containing ketoconazole 2% w/w. **Indications:** For the treatment of the following mycotic infections of the skin: tinea pedis, tinea cruris and candidal intertrigo. **Dosage and Administration:** For topical administration. For tinea pedis, Daktarin Gold cream should be applied to the affected areas twice daily. The usual duration of treatment for mild infections is 1 week. For more severe or extensive infections (e.g. involving the sole or sides of the feet), treatment should be continued for 2-3 days after all signs of infection have disappeared to prevent relapse. For tinea cruris and candidal intertrigo, apply cream to the affected areas twice daily until 2-3 days after all signs of infection have disappeared to prevent relapse. Treatment for up to 6 weeks may be necessary. If no improvement is experienced after 4 weeks treatment, a doctor should be consulted. **Contraindications:** Ketoconazole cream is contra-indicated in patients who have shown hypersensitivity to any of the ingredients or to ketoconazole itself. **Precautions:** Not for ophthalmic use. **Side Effects:** A few instances of irritation, dermatitis and burning sensation have been observed during treatment with ketoconazole cream. **Legal Category:** P. **PL Number:** PL 00242/0107. **PL Holder:** Janssen-Cilag Limited, Saunderton, High Wycombe, Buckinghamshire, HP14 4HJ. **Package Quantities, Price:** 15g tube, £4.99. **Date of Preparation:** February 2003.

Wholesalers back fuel fee

Pharmacists could be hit with a fuel surcharge by wholesalers as operators struggle to absorb the impact of rocketing oil prices.

Wholesalers backed an extra fee to cover record fuel costs, which have been hit by security fears in Saudi Arabia and are predicted to increase further after Hurricane Katrina disrupted oil production in the Gulf of Mexico.

Operators were "within weeks" of implementing the surcharge, according to wholesaler Phoenix. Average UK fuel prices of over 90p a litre for unleaded petrol and 94p for diesel had triggered wholesalers to act, commented David Cole, chief executive at Phoenix.

"We've had discussions with the Department of Health about introducing a fuel surcharge and their reaction was neutral.

"If the US situation pushes oil prices higher we'll have to pass that cost on to customers. We're close to deciding if that's the case in the next few weeks," he said.

Phoenix's pharmacy customers could pay around £10 a month to compensate for the wholesaler's rising fuel bills, according to Mr Cole.

High pump prices meant fuel costs were running at an unsustainable 0.25 per cent of sales at Phoenix, added Mr Cole.

Other full-line wholesalers also backed the introduction of a supplementary fuel charge to pharmacists. John Davies, retail services director at wholesaler Mawdsley Brooks, commented: "If fuel costs continue to increase then it's possible we will start to look at passing some of the extra charges to customers. Wholesalers have a very high level of service but that comes at a price."

Mr Davies revealed Mawdsley Brooks had secured a reserve fuel supply from a major petrochemical supplier to protect against a repeat of fuel protests, which caused disruption in 2000.

Wholesaler UniChem called on the Government to recognise the vital aid supplied by wholesalers by offering operators relief from high fuel costs. Julian Streeter, operations director, UniChem, said: "I urge the Government to consider our position. Surely some provision should be made for those who are delivering essential healthcare supplies?"

Oil prices topped $67 a barrel as *C&D* went to press. **MG**

PRACTICE

Returnees must demonstrate capability

The RPSGB believes that those who leave the pharmacy profession and then wish to return should be required to update their skills if they have spent more than one year out of practice. They should also be able to demonstrate that skills and knowledge have been updated and safeguards should be built into the system to prevent abuse.

"The important thing is not the length of time spent updating skills and knowledge, but rather the activities undertaken," says Mandie Lavin, director of fitness to practise and legal affairs at the RPSGB, in the Society's response to the Health Professions Council *Returners to Practice* consultation document that closes on September 9. It is envisaged that any proposals will be implemented in January 2006.

The Society believes the protection of the public requires "nothing less than that any person seeking to return to practice after five years be required to complete a course approved by the HPC". They must be able to demonstrate, against consistent measurable criteria, that they are fit to practise. "At the very least, the person wishing to return must be required to demonstrate that he has the knowledge and skills required of a newly qualified registrant, just admitted to the Register," says the Society.

The Society argues that the HPC must produce detailed and clear guidance. Those returning to practise should contact both an educational establishment and a professional supervisor, approved by the HPC, it says. **JE**

One trusted maker, two trusted medicines

For children's pain and fever, healthcare professionals usually recommend paracetamol-based medicines such as Calpal first. In fact, Calpal is the number one recommendation for many.[1,2] Calpal is effective and can be used for babies from 2 months.

When recommending a second option, you know parents want a medicine they can trust.[3] Calprofen is an ibuprofen for children over 6 months. For parents it's a reassuring alternative because it's from the makers of Calpal, children's medicine specialist for 39 years.[1] Just like Calpal, Calprofen has a great strawberry taste to make dosing easier. Calpal and Calprofen – recommend with confidence.

Children's medicine specialist

Colpol Infant Suspensions Product Information: Presentation: Suspension containing 120mg Paracetamol per 5ml **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Dosage:** *Children 1 to under 6 years:* 5 – 10ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. *Children 3 months to under 1 year:* 2.5 – 5ml; Repeat dose every 4 hours if necessary, up to a max of 4 doses in 24 hours. *Infants 2-3 months:* Post - vaccination fever at 2 months: 2.5ml and a second dose, if necessary, after 4-6 hours.Treatment of mild to moderate pain and as an antipyretic (Infants over 4kg, not born before 37 weeks) 2.5ml and a second dose, if necessary, 4-6 hours later. **Contraindications:** Hypersensitivity to paracetamol. **Precautions:** Caution in severe hepatic or renal dysfunction. Interactions with Domperidone, metoclopramide, colestryamine, anticoagulants, barbiturates, tricyclic antidepressants, alcohol, anticonvulsants and oral steroid contraceptives. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Rarely skin rash, other allergic reactions and blood dyscrasias. Hepatic necrosis and papillary necrosis have been reported following prolonged use. **RRP (ex-VAT):** 70ml bottle £1.66, 140ml bottle £2.97 12 x 5ml sachets £2.34. **Legal category:** Bottle: P. Sachets: GSL **PL holder:** Pfizer Consumer Healthcare, Walton-on-the-Hill, KT20 7NS. **PL number:** Calpal Infant Suspension: 15513/0004 **Date of preparation:** November 2004.

Calprofen Product Information: Presentation: Suspension containing 100mg Ibuprofen per 5ml **Uses:** Treatment of mild to moderate pain and as an antipyretic. **Dosage:** *Infants 6-12 months:* 2.5ml three times a day, *Children 1-2 years:* 2.5ml three to four times a day, *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years:* 10ml three to four times a day. Not recommended for children weighing less than 7kg. **Contraindications:** Hypersensitivity. History of peptic ulceration. Individuals in whom Ibuprofen, aspirin or other non-steroidal anti-inflammatory drugs induce asthma, rhinitis or urticaria. **Precautions:** Hepatic or renal dysfunction, heart [illegible] with coagulation defects or receiving anticoagulant therapy, [illegible] asthma or allergic disease. Care should be taken with [illegible] diuretics, cardiac glycosides, lithium, methotrexate, [illegible] other analgesics, corticosteroids, anticoagulants, [illegible] **Pregnancy and lactation:** Not recommended. Side effects: disturbances, occasionally gastric ulceration and [illegible] reactions and oedema. Other reactions that have been [illegible] ibuprofen include renal and liver problems, [illegible] haematological disorders and photosensitivity. **RRP (ex-VAT):** [illegible] **category:** P **PL holder:** Pfizerpharm [illegible] Clonmel, Co Tipperary Ireland **PL number:** [illegible] **revision:** April 2005

References: 1 Counterpoint Analgesics – Circle 03 2004 [illegible] Healthcare Network DFU Feedback 2005. 3 Colpol [illegible] Research, December 2003. Felicity Rando-Evans Associates

Pfizer Consumer Healthcare
www.calpol.co.uk

PAGB PERSPECTIVE

A parallel universe of imports

Do you ever feel you are operating in a parallel universe, asks Sheila Kelly, executive director, Proprietary Association of Great Britain

The big issue for pharmaceutical companies now is getting ready to introduce Braille on all the packs of new products from November this year and planning a programme to test all their leaflets with consumers to prove that they are readable and understood.

This is a massive exercise, probably the biggest change in medicines packaging in 30 years. It will be costly and it will divert both time and money away from other initiatives. But the driver is new EU pharmaceutical directives, geared to improving patient safety, not just free movement of goods. This means the industry doesn't get a lot of sympathy when we talk about the size of the workload and the costs of the redesigns of packs, stock handling and consumer research. (Each consumer test is around £15,000 and every leaflet needs to be tested: do the math, as they say in the US.)

Where does the parallel universe come in? Well, I picked up my prescription from my local pharmacy the other day and got a parallel import. My last pack was of UK origin, this one comes from Spain. The company is the same, the brand name is different and the tablets are completely different shapes. The UK blister was a silver calendar pack, the Spanish one is gold and 15 tablets on a tray – at least there were before the pharmacist snipped two off to make it a box of 28 instead of 30.

The UK leaflet was easy to read, in large print

The UK leaflet was easy to read, in large print, but the parallel importer has otherwise done the minimum to meet regulatory requirements. The box has been overlabelled with the UK brand name so the inner and outer names are different, the statutory warnings are in capital letters which are not easily readable but that doesn't matter because the label is also obscured by the dispensing label. Is it any wonder patients get confused and compliance is a problem?

If the box had Braille on it then I doubt whether any of it could be felt through the overlabelling. If the industry is changing packs to improve patient safety then surely what happens with dispensed packs should be relevant and support that goal.

I know all the arguments about costs and the pressure for pharmacists to source their supplies from the cheapest supplier but this just looked unprofessional. I see all the pharmacy bodies are pushing for original pack dispensing. If anyone wants my pack as a visual aid in the lobbying I would willingly donate it.

E-mail your views to chemdrug @ cmpinformation.com

Toxic shock and tampons

I was concerned to read a brief article in *C&D (August 13, p23)* in which a retailer claimed that Sea Pearls – natural sea sponges used in place of tampons for internal sanitary protection – reduce the risk of toxic shock syndrome (TSS).

To the knowledge of this organisation which represents the UK manufacturers of the sanitary protection, disposable nappy and continence care industries, there is no evidence whatsoever to show this to be true, and this statement could risk a false sense a security among women using Sea Pearls.

In fact, unlike mainstream tampons, Sea Pearls are unlikely to have been subjected to any in-depth scientific research and therefore the potential for any adverse or indeed beneficial, health effects are unlikely to be known.

Unlike tampons, which are produced to pharmacopoeia standards of hygiene, and which are disposed after each single application, the retailer claims that only two sponges are required over a six month period and recommends they are simply rinsed in water after use. This cannot compare in any way with the hygiene offered by disposable tampons and we would be interested to know if this practice is supported by research which proves it to be acceptable in terms of health and hygiene.

The article also claimed that Sea Pearls are free from dioxins, rayon and synthetic fibres and that this is the reason for the reduction in risk of TSS. None of the aforementioned are responsible for TSS, and it should also be noted that dioxins are ubiquitous and are found at trace levels in all organic materials; sea sponges are unlikely to be an exception to this.

TSS is a bacterial infection which can affect any member of the community, men women and children, as well as women who are menstruating and using internal sanitary protection. The causal link between the former and TSS is unclear. For further information visit *www.tssis.com.**

Tampons are made from cotton, rayon or a blend of the two. Fibres are non-elementary chlorine bleached as this process is known to give rise to dioxin production, and this is in line with a Code of Practice which exists between AHPMA members and the DTI.

We have no issue about the marketing of alternative products, but must take issue with claims which wrongly denigrate mainstream tampons.

For further information please contact AHPMA on 01483 418221.

Tracy Stewart,
director-general, Absorbent Hygiene Products Manufacturers Association (AHPMA),
46 Bridge Street,
Godalming,
Surrey GU7 1HL.

** The Toxic Shock Syndrome Information Service (TSSIS) was set up around 10 years ago and is funded by the UK tampon industry.*

A £50 consultation fee would be more realistic

There's little wonder that pharmacy contractors in general are feeling thoroughly frustrated at being under-remunerated and exploited when they see their local GPs' hours reduced to nine to five weekdays only, and their salaries raised by 30 per cent.

Then they read of Bracknell community pharmacists accepting and bragging of a measly £5 consultation fee (*C&D, August 20, p10*).

It is crystal clear why the PCT pharmaceutical advisor states that "the GPs all love it". This is typical of the wishy-washy PCT thinking on the true value of a comprehensive pharmaceutical service.

If community pharmacy was perceived as and acted as a united profession and an equal partner in the primary care team, a true and meaningful fee for this coeliac consultation would be £50.

David Thomas MRPharmS,
Patshull,
Shropshire.

Double strength Canesten 2% thrush cream for him can help prevent thrush re-infection for her

Canesten®

THRUSH CREAM

Clotrimazole 2% w/w

Immediate soothing relief of external thrush symptoms

Contains clotrimazole

Women know they can find rapid relief and resolution from thrush using Canesten. But there's one more thing that you can do for them.

Recommend double strength Canesten 2% thrush cream for their male partners. An effective way to help stop her thrush coming back.

Canesten® Thrush Cream – Product Information. Presentation: *Canesten Thrush Cream* contains clotrimazole 2% w/w. **Indications:** Treatment of candidal vulvitis. To be used as an adjunct to treatment of candidal vaginitis. Can also be used for treatment of the sexual partner's penis to prevent re-infection. **Dosage and Administration:** *Adults:* Apply to the vulva and surrounding area two or three times daily and rub in gently. Treatment should be continued until symptoms of the infection disappear. If after concomitant treatment of the vaginitis, the symptoms do not improve within seven days, the patient should consult a physician. If the cream is being used for treatment of the sexual partner's penis it should be applied two or three times daily for two weeks. *Children:* There is no clinical experience in the use of Canesten Thrush Cream in children. **Contra-indications:** Hypersensitivity to clotrimazole. **Warnings and Precautions:** A physician should be consulted if this is the first time the patient has experienced symptoms of candidal vaginitis or if any of the following are applicable: more than two infections of candidal vaginitis in the last six months; previous history of or exposure to partner with a sexually transmitted disease, pregnancy or suspected pregnan[illegible] under 16 or over 60 years, known hypersensitivity to imidazoles or other vagina[illegible] products. Medical advice should be sought if the patient has any of the following: [illegible] irregular vaginal bleeding, abnormal vaginal bleeding or a blood-stained discharge, [illegible] ulcers, blisters or sores, lower abdominal pain or dysuria, any adverse events such [illegible] irritation or swelling associated with the treatment, fever or chills, nausea or vomit[illegible] foul smelling vaginal discharge. This product may damage latex contraceptives [illegible] should be advised to use alternative precautions for at least five days after [illegible] **effects:** Rarely, local mild burning or irritation immediately after use. Hyper[illegible] occur. **Use in Pregnancy:** Only when considered necessary by a physician. **Cost:** [illegible] **MA Number:** PL 0010/0077. **MA Holder:** Bayer plc, Consumer Care Division, [illegible] RG14 1JA. **Legal Category:** P. **Date of Preparation:** October 2[illegible] Bayer AG.

Canesten® can

Our question to pharmacists this week was:
Who will win the World Cup qualifier on September 3?

"I hope Wales does, but it's a rugby nation so I'm being realistic and saying England"

Avril Matthews, Swansea

"I would expect England to win as they are a better team"

Malcolm Birrell, Chester

Our online poll at *www.dotpharmacy.com* said...

England 83%

Wales 17%

Comment from the Editor

Homoeopathy doesn't work. What's new, you might ask. Well, where's the research saying psychiatry or cognitive behavioural therapy doesn't work, either? After all, it can only be the hour-long consultation that leads to any improvement in the homoeopathy patient, as we know the pillules are only lactose.

As a holistic 'talking cure', then, it doesn't stand up to double blind randomised trials like 'real' medicines do, hence the criticism. But it's not quite as simple as that. Homoeopathy likes to cloak itself in mystique – using a Bible to succuss the tinctures to impart the power to the next dilution is a case in point. But it may be this sort of ritualistic mysticism which many people find attractive as it fits in with the belief system of the mysterious world they live in.

Should pharmacists take the advice of *The Lancet* which this week is asking doctors to be "bold and honest" in telling patients about homoeopathy's lack of benefit? Probably not.

Homoeopathy may have endured as an upmarket version of the snake oils of old, albeit without the chance of noxious substances causing side effects. But as long as the patient is aware of the limitations of any treatment, then it is surely up to them to decide where they want to spend their money.

The Lancet study did not find that homoeopathy was completely ineffective, but that it was only effective as placebo. By inference, some people benefit. By being big enough to tolerate homoeopathy, allopathic practitioners will win more friends than by actively discouraging competing therapies. So rather than discrediting the competition, energy should be spent flagging up the benefits (and pitfalls) of modern medicines.

An informed public can make its own judgements. It doesn't need the doctor (or a pharmacist) to decide for it.

"An informed public can make its own judgements"

Yourviews

E-mail your views to chemdrug @ cmpinformation.com

Independents need a voice like multiples

The announcement last week of the necessary and inevitable bid by Phoenix for Numark (*C&D, August 20, p4*) was one of the worst kept secrets in the industry.

Numark's shareholding members will undoubtedly be relishing their windfall and return on their prescient investment. Less obvious, however, are the repercussions of a takeover by a multinational wholesaler and retailer on their business and, possibly, some of the medium sized wholesalers whose brainchild Numark was. It was reported that Numark would remain separate from Phoenix and "would focus exclusively on supporting independent pharmacy". Which, in this context, presumably includes the "384-strong Rowlands Pharmacy chain" – current members of Numark.

There has been much debate recently about who exclusively looks after the interests of independent pharmacy and even the suggestion of a separate body to do this. AAH's MD, Steve Dunn, recently observed: "This is Darwinism in action. The world changes and we have to adapt to that. Wholesalers who do not will die out" (*C&D, August 20, p28*). I wonder if this may not be evolution, but "intelligent design".

However, the new contract is insisting that pharmacy no longer operates in splendid isolation but becomes an integral, important and measurable part of delivering healthcare within the NHS, especially in the community. Accordingly, the vast majority of independent pharmacies are looking for support in delivering against these ambitious objectives. There are many organisations only too willing to offer assistance, however their motives are often ambiguous. Corporate consolidation is inevitable and the vertically integrated wholesalers will grow inexorably.

Nucare believes that a vibrant independent pharmacy sector is vital in order for the profession to achieve its goal of integrating fully, and offering choice, in this brave new world.

Any independent contractor who is a member of a 'buying group' needs to seriously consider the level of support that is on offer. Good terms are no longer enough – independent pharmacy requires the same voice, support and resources as large multiples.

Michael Major, chairman, Nucare Plc.

Northern Ireland NOTEBOOK

TOPICAL REFLECTIONS

Science fails to discredit homoeopathy

Another scientific study has found that homoeopathy does not work, but I doubt whether many users of homoeopathic medicine really care. Most patients put their trust in the form of medicine which has worked for them in the past or the one they believe will work in a particular instance. This belief is not generated simply by scientific studies or the word of the GP.

Patients switch to a different form of medicine if they become disillusioned with their current treatment. I'm sure many of the patients suing Merck for their Vioxx induced side effects will be considering a switch, for example. And patients don't need studies to tell them their treatment is working. We all know allopathic medicines that have been proved to be 'ineffective' yet some patients still improve after taking them.

It is well accepted that, because homoeopathy is a holistic medicine, randomised controlled trials are not the best way to measure its effectiveness. And because it is so different to allopathic medicine a comparison between the two is of little value.

A little safety goes a long way where health is concerned and this must be one of homoeopathy's trump cards. Patients taking paroxetine or Chinese medicine would rightly be concerned after reading last week's issue (*C&D, August 27, p8 & 20*). But I don't recall ever reading a story of this nature about homoeopathy.

Part of the attraction of alternative medicine is that it is just that – an alternative to conventional medicine without many of its drawbacks. I suspect that the more the scientific community rejects homoeopathy in studies like *The Lancet*'s the more 'alternative' it will become, making it more attractive still. If homoeopathy has worked for someone it is very unlikely they will ever be convinced that it was a figment of their imagination. Many of my patients do not care that antihistamines, for example, are 'proven' if the homoeopathic alternative works for them. Chamomilla worked like magic for my children's teething pain where conventional treatments were of little help. Even if it was magic I wouldn't have cared. Who in their right mind will persist with a conventional treatment that isn't working if they have an alternative that is?

Homoeopathy would not have survived for 250 years if it didn't work. I believe it will survive well into the future, perhaps even after allopathic drugs have been superseded.

A mixed prescription across Europe

News of pharmacy from other parts of Europe always makes interesting reading and while last week's article (*C&D, August 27, p28*) made me a little jealous of our Swiss and German colleagues I'm grateful that I wasn't born Romanian.

Swiss and German pharmacists have been living on some cushy numbers but the authorities have caught up with them and it looks like the good times are over. Swiss pharmacists have been claiming about £20 annually per patient simply for keeping medication records. Wow! And there are 1,700 pharmacies in this small country. No wonder the Swiss OFT wants to cut pharmacy numbers.

It sounds like pharmacists in Germany do pretty much as they please, making illegal generic substitutions at will. And rebates in kind at a 1:1 or even 1:2 ratio for generics sounds too good to be true. Of course it was too good to last and cutbacks sound inevitable.

Pharmacy, in fact the whole healthcare system in Romania, is in a dire state with bankrupt pharmacies unable to dispense prescriptions. There is a lesson for our own DoH here. The main cause of the problem has been a lack of funding; pharmacists are rejecting prescriptions because it takes so long to get reimbursed, and patients are suffering. Now when I feel down about pharmacy I simply have to think about Romania.

Is prejudice justified?

Over the years I've tried to avoid stereotyping those I serve. When first in practice if I suspected a shoplifter I watched he didn't pilfer stock; if she looked like an addict I suspected she would try to defraud me; if they wore stretch-hooded coats I suspected they would make trouble.

Stereotyping, I have found, was of little practical use as mostly I was wrong and my prejudice severely impeded me. Of this I am ashamed since prejudice truly is anathema to professionalism. So, to remedy things I have tried to speak in a kind and caring manner to all, including those I might suspect of errant ways.

And so it was last Friday. The young man's prescription was for painkillers and he stood ill at ease in the shop. The scars on his face were beginning to heal yet there was an angry circular bloody scab on his right cheek just below his eye. A web of six to eight slash

The scars on his face were beginning to heal

cuts radiated from this point. On the left side of his face was a single slash cut from his ear down his cheek towards the side of his mouth. His left ear was cut off, the remaining stub stitched.

His eyes were defiant, his stance arrogant and he smelled of sweat and alcohol. As I instructed him on his painkillers I tried not to show alarm. Once he found me friendly he relaxed; he listened and asked my advice on keeping his facial wounds clean. I praised the hospital staff who stitched the wounds.

I felt sorry for him. It was only afterwards that I remembered the name on his prescription: he was found guilty of robbing a man at knifepoint in 1999.

Written by a pharmacist practising in Northern Ireland

Fit for **purpose**?

David Reissner and Noel Wardle describe the fitness to practise regulations, and consider some practicalities

As part of the new control of entry regulations which came into force on April 1, 2005,[1] all PCTs must compile a 'Fitness to practise register', by a month from now, October 3, 2005. Fitness to practise information must also be provided by every new applicant for a pharmacy contract.

Fitness to practise register

Facts which all existing pharmacy owners and future applicants must disclose include:

- Any convictions or ongoing criminal investigation or pending prosecution;
- Any adverse findings or ongoing investigations by the Royal Pharmaceutical Society or the NHS Counter Fraud Service.
- Any ongoing investigations by another PCT.

In compiling the register, the information must be given by the pharmacist owner or, in the case of a company, by the pharmacy superintendent and all directors.

The owner of a multiple need only provide the information to the PCT in which the company's head office or registered office is located (the 'home' PCT). The home PCT is then responsible for circulating the details to all other PCTs in whose areas the company has branches.

Applications

Similar information must be given to the local or home PCT by anyone applying for a new NHS pharmacy contract.

When an application is made for a new contract, the applicant (in the case of a company, the superintendent and any pharmacist director) must provide the names and addresses of two referees. The referees should ordinarily be two people with whom the applicant has worked in the last two years for a period of more than three months.[2]

Referees must be willing to provide a reference in respect of two recent posts (including the applicant's current post) as a pharmacist and the posts must have lasted at least three months.[3]

These arrangements seem particularly ill-suited to community pharmacy where pharmacists commonly work on their own and will frequently not have been in more than one post in recent times. If it is not possible to provide two referees willing to give references relating to two recent posts of at least three months, applicants should explain this fully and are then entitled to offer alternative referees.

PCT check

When considering any application from an applicant who is not already included in that PCT's pharmaceutical list, the PCT must:

- Check the information provided by the applicant.
- Ask the NHS Counter Fraud Service whether the applicant or any director or superintendent of a company which is applying has any record of fraud.
- Ask the Department of Health about any record held in relation to the applicant or any director or superintendent.
- Take up the references.

The PCT must then consider whether there are grounds for refusing the application or imposing conditions.

Refusal on fitness to practise grounds

The PCT can refuse an application where it considers that the applicant is unsuitable to be included in the list.[5]

The PCT should consider facts such as the nature of the incident, the length of time since the incident, any penalty imposed, and the relevance of an offence.[6] The PCT must refuse the application where the applicant has been convicted of murder, imprisoned for more than six months, struck off the pharmaceutical register or failed to update his application where it has been deferred on fitness to practise grounds (for deferral, see below).

The applicant may appeal the decision to refuse an application. The appeal must be lodged with the FHSAA within 28 days[7] of the notification.

Approval subject to conditions

The PCT may grant an application subject to conditions[8]. The conditions must be with a view to preventing any prejudice to the efficacy of pharmaceutical services or preventing fraud.[9] The applicant must notify the PCT within 28 days if he accepts the conditions. He has 28 days to appeal the decision of the PCT to impose conditions.

Deferment of consideration of application

Where the applicant is the subject of any ongoing criminal or regulatory investigation or is appealing the decision of a PCT to refuse an application on fitness to practise grounds, the PCT can defer the determination of his application until the applicant notifies the PCT that the investigation has concluded and what the outcome was.[10]

However, the PCT can only defer consideration of an application if removal from its pharmaceutical list would be justified after a conviction or finding of guilt.[11]

Continued on page 18 ▶

Hands up who wants great-tasting Omega-3...

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* Preferred by children to number 1 competitor product by a factor of 2 to 1, data on file March 2005.

A delicious way to take Omega-3

Removal

Following a conviction, a PCT may remove a pharmacist from its pharmaceutical list on fitness to practise grounds.[12] It must give the pharmacist notice in writing of its intention together with the reasons for its decision.

The PCT must take into account the nature of the offence, the length of time since it was committed, its relevance to the provision of pharmaceutical services, and any risk to the public. The contractor has 28 days to make submissions and request an oral hearing, if he so wishes. He has 28 days to appeal against the decision and any such decision is stayed while the appeal is pending.

Suspension

The PCT has the power[13] to suspend a pharmacist to protect the public where criminal or disciplinary proceedings are ongoing.

Where a pharmacist is suspended by the PCT, he may appoint a temporary pharmacist to run the pharmacy in his place[14]. The temporary pharmacist must provide the PCT with the fitness to practise information set out above and satisfy the fitness to practise tests. The temporary pharmacist should not be closely connected to the suspended pharmacist (for example as an employee or a family member).

The PCT must determine the temporary pharmacist's application within 14 days of receiving it or within 14 days of receiving written representations from the suspended and temporary pharmacist should these have been requested.

The PCT must make payments to any suspended pharmacist in accordance with the rate published in the *Drug Tariff*.[15]

Summary

Requiring pharmacy applicants to provide references and PCTs to check the suitability of applicants has obvious benefits, but inevitably will create difficulties for PCTs and applicants.

The compilation of fitness to practise records for all existing contractors, and the duty to take up references and make other enquiries will be burdensome for PCTs at a time when they are coming to grips with the new pharmacy contract and the other detailed requirements of the new control of entry regulations.

These burdens are compounded by the new obligation imposed on PCTs to determine applications within four months. The primary requirements for referees are not compatible with the way in which pharmacists work in community pharmacies. There is also scope for unfairness to applicants who may not know that they are under investigation.

Even if applicants are the subject of a complaint, they must be presumed innocent until proved guilty. PCTs will need to be very careful to take a proportionate approach to an application if they learn of a pending investigation.

Where there are competing applications, a deferral of an application may allow a competitor to succeed at the expense of a pharmacist under investigation. If the accusation is not substantiated, it may be impossible to provide the unsuccessful applicant with an adequate remedy.

The existence of a right of appeal may offer aggrieved applicants some hope of justice, but the appeal process could, itself, take so long to complete that the purpose of the appeal is frustrated. Fitness to practise should not exclude fairness to practitioners.

David Reissner is a partner and head of the pharmacy group, and Noel Wardle is a solicitor at Charles Russell LLP, Solicitors.
www.charlesrussell.co.uk

1. The National Health Service (Pharmaceutical Services) Regulations 2005.
2. Paragraph 7, Schedule 4, Part 3.
3. Paragraph 6, Part 3, Schedule 4.
4. Regulation 24.
5. Regulation 19(2).
6. Regulation 19(4).
7. Regulation 19(7).
8. Regulation 21.
9. Section 43ZA, NHS Act 1977.
10. Regulation 26.
11. Regulations 26 and 46.
12. Regulation 48.
13. Section 49, NHS Act 1977.
14. Regulation 54.
15. Regulation 58.

CPD

This article can help in the following CPD competencies: **G1a, G1e, C2a, C1f** A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Once bitten...

In the first of two articles on malaria, *Larry Goodyer* describes symptoms and treatment

Until the beginning of the 20th century, malaria could be found in parts of England. However, even though the disease is not as widely distributed now as in previous years, it remains the biggest killer of all the infectious diseases.

The recent World Health Organization *Roll Back Malaria* campaign has been largely unsuccessful and tropical Africa is trying to cope with the double problem of AIDS and largely out of control malaria. Annually, there are around 500 million cases of malaria worldwide resulting in over one million deaths, the majority in young children.

Against this background it is not surprising that malaria presents a significant risk to the traveller, with around 30,000 people per year from North America and Europe contracting the disease. Of all the tropical diseases a traveller might encounter, malaria is of the greatest concern and one which all health professionals responsible for such travellers must be fully aware.

Currently the UK has one of the highest incidences in the world of travellers returning with malaria, higher than the USA and second only to France. Figures show that in 2003-04 1,722 UK travellers contracted malaria and 16 died. Alarmingly, there was a rise in the proportion of cases contracting *Plasmodium falciparum*, the most dangerous form of malaria, compared with previous years. Nearly half these cases were people leaving the UK to visit friends or relatives overseas; the reasons for this will be discussed later in this article.

The community pharmacist can play an important role in advising and preparing travellers planning to visit malaria endemic areas. This includes education on the risks of malaria, the appropriate use of chemoprophylaxis and on bite avoidance measures. It is worth noting that far more travellers visit a pharmacy to prepare themselves for a trip overseas than will arrange an appointment with a GP or practice nurse.

Sinclair Stammers/Science Photo Library

Malaria is transmitted by the female anopheles mosquito

The aim of this first article is to cover some general background information concerning malaria and the range of advice that could be offered by community pharmacists. The next article will focus specifically on malaria chemoprophylaxis.

Life cycle of parasite

The key to understanding malaria, and the way in which prophylactic agents are used, is in the lifecycle of the malaria parasite. This is shown diagrammatically in Figure 1, and Figure 3 shows the stages at which various antimalarials have their action, although these will be discussed more fully in the next article.

The disease is transmitted by the bite of the female anopheles mosquito, which requires a blood meal for development of its eggs. The eggs are then laid in stagnant water and develop into free-swimming larvae. To transmit malaria, the mosquito must pick up the sexual state of the parasite (gametocyte) with the blood meal; this matures in the mosquito into a sporozoite that can be transferred to another human when the mosquito feeds. The sporozoites travel rapidly to the liver where they subsequently infect hepatocytes.

Once inside the hepatocytes the parasite is effectively protected from the immune system and also some drug therapies, which makes effective vaccine and medication development difficult. Within the hepatocytes there is further development and multiplication until many thousands of merozoites are released to invade red blood cells. These will also divide and develop within the red blood cells, releasing merozoites to invade further red blood cells.

Signs and symptoms

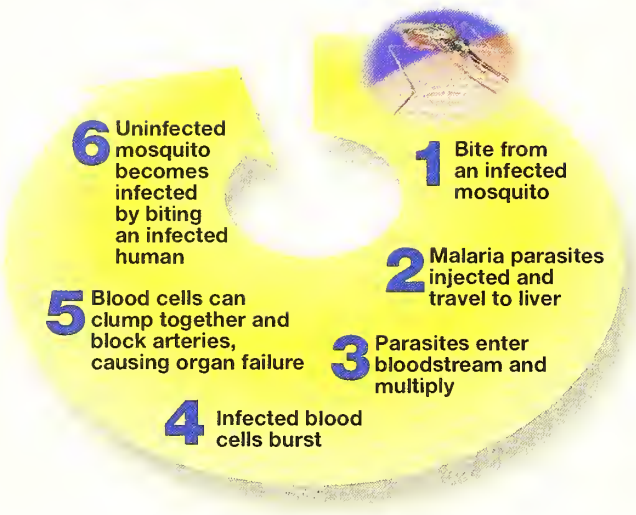
Although the initial presenting symptoms may be similar for the different forms of malaria, the resulting complications and disease course can be different. Classically malaria is considered as a malignant form if caused by infection with *P falciparum* and benign form if infection is by *P vivax*, *P malariae* or *P ovale*, of which *P vivax* is the most common.

Initial symptoms for all forms of malaria include fever and chills, muscle and joint pains, headache, malaise and sometimes nausea and diarrhoea, and can be difficult to differentiate from other flu-like illnesses. With the benign forms, a synchronicity can develop as the red blood cells rupture with release of the merozoites every two to three days. Apart from these quite debilitating fevers the benign forms do not usually cause any particular complications in healthy adults, although anaemia can develop. Another feature of *P vivax* and *P ovale* is that they can form a long lasting liver stage, called hepatozoites, which can result in recurrent symptoms for many years.

After being bitten by a mosquito symptoms take at least 1 week to develop and may not appear for up to a year. However the usual maximum is around three months for falciparum

Continued on page

Figure 1: Malaria parasite lifecycle



malaria as it does not form hepatozoites.

Of greatest concern to the traveller is infection with *P falciparum*, which can progress from initial symptoms to death in as little as 24 hours if prompt treatment is not given. In this form the fevers tend to be more irregular and severe complications can arise because of a particular effect of the parasite on the red blood cell membrane. This can cause the cell to adhere to blood vessel walls, resulting in sequestration of the infected red blood cells in deep tissues of various organs, particularly the brain where cerebral malaria can develop. This is an immune response to the sequestered red blood cells within the blood vessels rather than the parasite itself, and can lead eventually to coma and death.

There are two important risk groups for malaria: children and pregnant women. Travel to malaria endemic areas should be discouraged during pregnancy because of the high risk of abortion and maternal fatality. Similarly, the World Health Organization has advised against children travelling to malaria endemic areas as the disease can be more severe and progress at a faster rate than in adults.

Consideration must be given to the potential to develop resistance. Resistance is not developed to the benign forms, although the red blood cells of the indigenous population have adapted in some cases, for instance the sickle cell trait results in less severe malaria. In falciparum malaria a semi-immunity can develop in those living in malaria endemic areas, but those with an impaired immune system would still be prone to the disease.

However, immunity does wane if the individual is not continuously exposed to malaria, and is therefore lost after several months in those who emigrate to non-endemic countries. This is the reason behind the high incidence of malaria in those visiting friends and relatives as individuals may still believe they are immune and not take the necessary prophylactic measures.

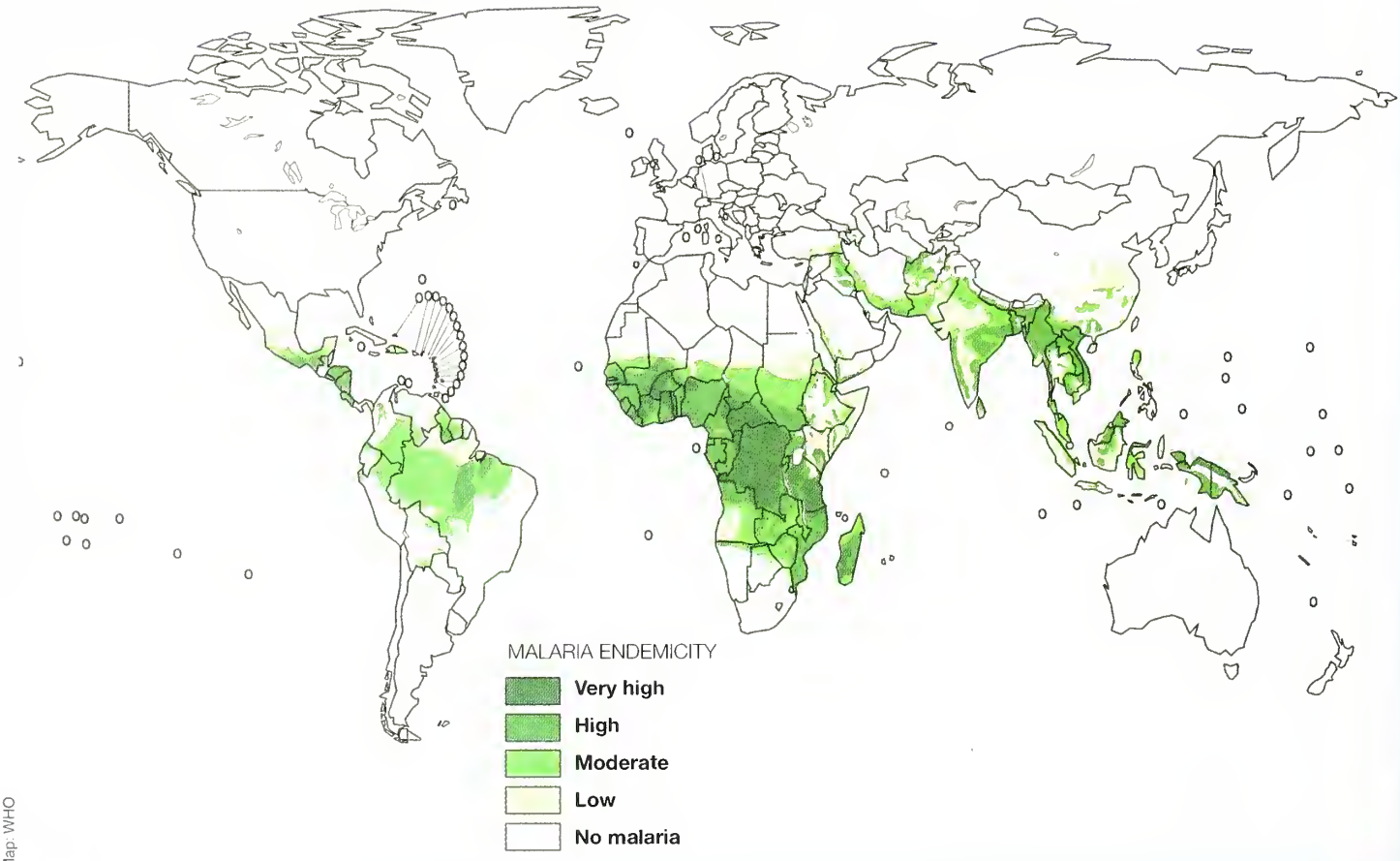
Distribution and level of risk

Malaria is found within a broad band between the tropics as shown in Figure 2. *P falciparum* is dominant in much of sub-Saharan Africa and parts of South East Asia, whereas *P vivax* tends to be more dominant in more temperate areas such as central America. Other areas such as India and South America present a mixed picture of these forms.

It is important to distinguish where *P falciparum* might predominate, as in many parts of the world there is a high incidence of chloroquine-resistant strains. The risk of contracting malaria tends to be lower in urban and coastal areas, although this is a generalisation as certain cities and coastal resorts can be affected.

Generally, malaria is of lower risk in situations where exposure to mosquitoes is reduced. Thus people visiting areas above 2,000 metres, where mosquitoes tend not to be present, are at a lower risk. Sleeping in sealed air-conditioned rooms also reduces exposure to mosquitoes. This is illustrated by research showing that airline crew members are at relatively low risk of malaria as

Figure 2: Global distribution of malaria transmission risk, 2003



Map: WHO

they often stay for short periods only in air-conditioned hotels in major cities.

Another factor affecting mosquito populations is the time of year relative to wet or dry seasons. For these reasons it may not be possible to generalise about a particular country's risk and close examination of the area being visited and time of year may be needed when advising travellers.

Advice to travellers

There is a useful way to remember the areas of advice that a community pharmacist can cover when discussing malaria with travellers – the ABCD rule.

- **Awareness:** Make travellers aware of the risks of malaria. Ensuring they appreciate that it is a serious condition and present at their destination.
- **Bite avoidance measures:** The anopheles mosquito tends to bite between dusk and dawn so people should be encouraged to wear long trousers and sleeves when going out at night. Insect repellents should be used on exposed skin and a room cleared of mosquitoes before retiring. If not sleeping in an air-conditioned room, an insecticide treated mosquito net should be used.
- **Compliance:** Taking the correct prophylactic agent is a key element of advice and will be described in the next article.
- **Diagnosis:** People should be aware of the early symptoms of malaria so appropriate treatment can be initiated promptly.

Treatment

An early diagnosis is extremely important in order to prevent complications, particularly those associated with falciparum malaria. If uncomplicated (for instance no cerebral involvement), oral therapy is feasible although all cases should be treated at a hospital or specialist unit. The antimalarial drugs used in prophylaxis are often employed in the treatment of uncomplicated malaria and the details concerning side effects and precautions will be discussed in the next article.

However, it is possible that community pharmacists may be asked to dispense what is sometimes referred to as Standby Treatment (SBT), which is intended for use by those visiting malaria endemic areas more than 24 hours from medical help. The rationale here is that as no prophylactic agent is 100 per cent effective, and failure is possible because of drug resistance or poor compliance, those who cannot gain reasonable access to medical facilities should be in a position to treat themselves. A few points are worth noting regarding SBT:

- In theory malaria due to *P vivax* could be treated with chloroquine, but because *P falciparum* is almost universally resistant to chloroquine this is rarely used in treatment, particularly for SBT.
- If SBT is prescribed by GPs, they should usually have asked for expert advice regarding suitability for the individual concerned.
- If malaria symptoms occur fewer than seven days after entering the area the traveller should be advised this is unlikely to be malaria.
- The drug used for SBT should not be the same one the individual has been prescribed for prophylaxis.
- The prophylactic agent should be continued during and after the SBT.

One of the most popular drugs for SBT is atovoquone/proguanil (Malarone) because of the low incidence of adverse drug reactions and a relatively simple dosage regimen. Also highly effective is lumefantrine/artemether (Riamet), which also has a good side effect profile but requires a somewhat more complex regimen. Mefloquine (Larium) can be used but CNS adverse effects are more common than when used for prophylaxis. The other option is a seven-day course of oral quinine (some sources stating shorter courses) together with doxycycline, although the adverse effects associated with cinchonism can limit the length of treatment. The treatment regimens for these are all described in the *British National Formulary*.

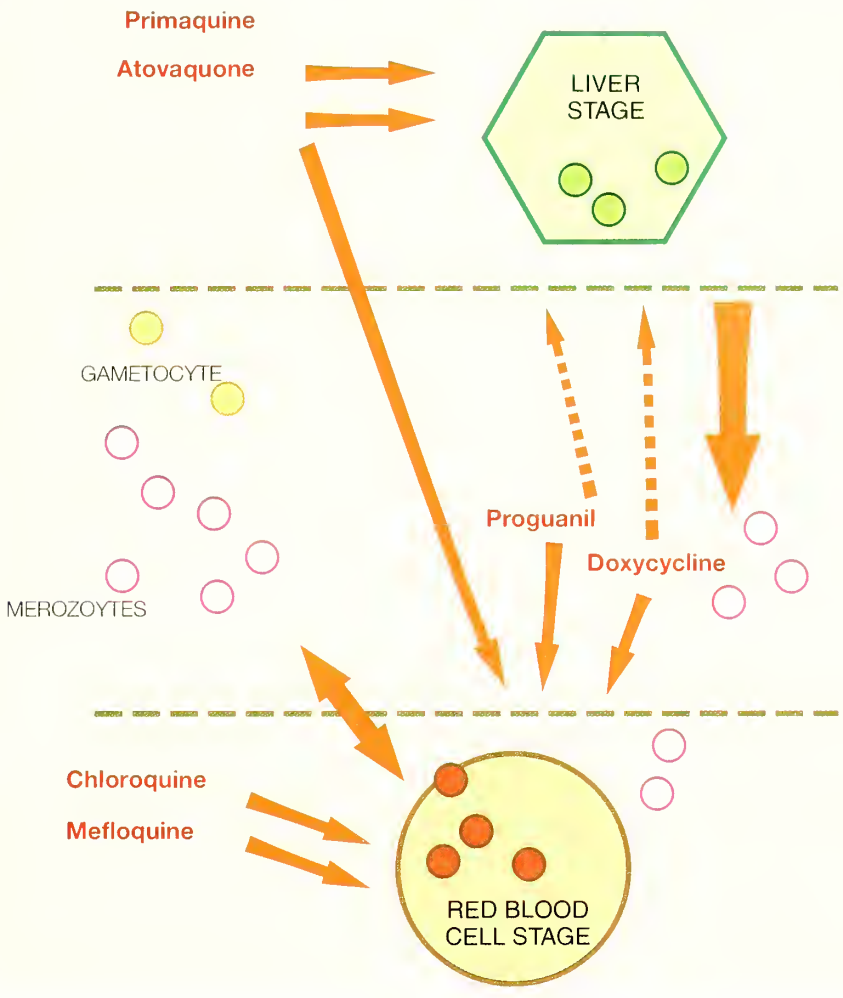
A further issue when contracting malaria overseas is that of accurate diagnosis, as in inexperienced hands the traditional blood film and microscopy methods can be unreliable. Travellers can buy immunological self-diagnostic finger prick tests, but these can be unreliable if travellers are not fully trained in their use.

For cases where there are complications and/or the patient cannot take oral medication then intravenous treatment is indicated. Traditionally intravenous quinine is used followed by either sulphadoxasone/pyrimethamine or doxycycline. This requires close monitoring for serious toxicity including hypoglycaemia, cardiotoxicity and seizures.

Artemesinin is becoming a popular alternative in many parts of the world, being a relatively affordable drug originally derived from the Chinese herb quinghaosu, for which there are now a number of semi-synthetic derivatives. This has a good side effect profile and there is little reported resistance. Parenteral forms of artemesinin are only available off-licence in the UK. The next article will deal specifically with antimalarials used for chemoprophylaxis.

Professor Larry Goodyer, PhD, MRPharmS, is head of Leicester School of Pharmacy, De Montfort University.

Figure 3: Lifecycle of malaria in the body and the stages at which antimalarials act



Homoeopathy works by placebo effect, says Lancet

The clinical effects of homoeopathy are placebo effects, a study in *The Lancet* has concluded.

The researchers compared 100 placebo controlled randomised controlled trials of homoeopathy with 110 conventional medicine trials matched for disorder and type of outcome. Although bias was present in both groups, the evidence for homoeopathy having a specific effect was weak, whereas there was strong evidence of conventional medicines having specific effects, say the authors.

But they add that more research is necessary, saying: "For some people homoeopathy could be another tool that complements conventional medicine, whereas others might see it as a purposeful and antiscientific deception of patients, which has no place in modern healthcare." Future work should concentrate on the nature of context effects and homoeopathy's place in healthcare systems, rather than placebo-controlled trials, they conclude.

An accompany *Lancet* editorial pronounces the results as "unsurprising", saying: "Of greater interest is the fact that this debate continues, despite 150 years of unfavourable findings." It calls for research to stop, saying that instead "doctors need to be bold and honest with their patients about homoeopathy's lack of benefit, and with themselves about the failings of modern medicine to address patients' needs for personalised care".

However, Nelsonbach chairman Robert Wilson opposes the journal's view, saying: "There is a need for greater understanding and transparency within the complementary and alternative medicines sector." Pointing to homoeopathy's 250-year history, he says the sector has prospered because of its "excellent record of successful use and safety" and claims: "There are many other studies, both clinical and non-clinical, than demonstrate homoeopathy's efficacy and safety in many disease areas."

Homoeopathy may have a long history of usage but its efficacy has been questioned by *The Lancet*

For more information:

Lancet 2005; 366: 726-32

FFPRHC guidance

The Faculty of Family Planning and Reproductive Health Care has issued two guidance documents – one on prescribing lamotrigine for women on oral contraceptives, and one on unlicensed contraceptives.

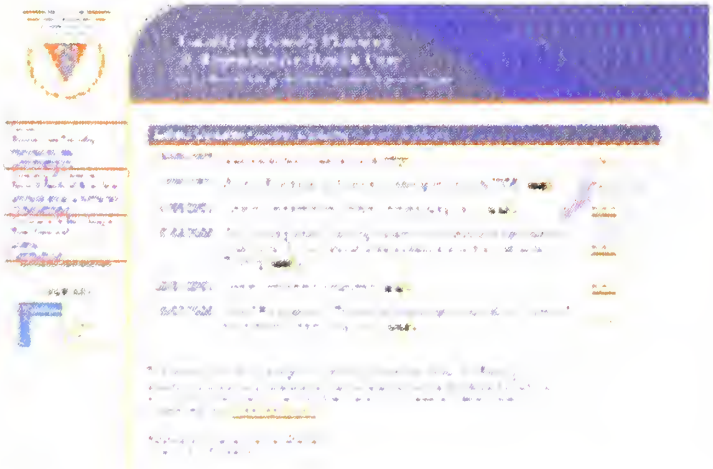
The first FFPRHC statement says that women on lamotrigine should be warned that seizure frequency may increase when combined oral contraceptives are initiated, and lamotrigine side effects may increase when COCs are discontinued. Prescribers are advised to warn patients of the possibility of drug interactions.

The second document outlines how contraceptives should be prescribed outside their product licences, because "SPCs often do not reflect current evidence and may be unnecessarily restrictive".

Advice is given on the use of progestogen-only emergency contraception beyond 72 hours, more than once in a cycle, and advance provision, though clinicians supplying EHC under patient group direction are reminded that the PGD must state why off-licence use is necessary.

For more information:

www.ffprhc.org.uk



Early statins reduce heart attack deaths

Taking a statin within 24 hours of a heart attack reduces mortality by more than half, say US researchers.

Analysing data from over 170,000 patients who were admitted to hospital following a myocardial infarction, the researchers found that those who had received statin therapy before they were hospitalised or within 24 hours of the MI were 54 per cent less likely to die in hospital than those not taking a statin. Furthermore, early statin use was associated with a lower incidence of complications, including cardiac arrest, shock, rupture, arrhythmias and ventricular fibrillation.

Lead study author and UCLA cardiology professor Gregg Funarow calls for the statins' cardioprotective effect to be investigated fully in a clinical trial. If his findings are corroborated, he believes statins should be administered to all MI patients presenting at accident and emergency departments.

For more information:

Am J Cardiology 2005; 5: 611-616

Canadian ADHD drug ban lifted

The Canadian drug regulator has allowed Shire Pharmaceuticals to resume sales of an ADHD product after a six-month suspension.

Health Canada requested the withdrawal of Adderall XR (amphetamine salts) in February after a safety review indicated the drug might be linked to a number of strokes and sudden deaths. In order to reintroduce Adderall XR to the Canadian market, Shire must follow a number of steps recommended by Health Canada, including revision of its prescribing and patient information to warn of the risk of sudden cardiac death in children. Adderall is not marketed in the UK.

For more information:

www.hc-sc.gc.ca

MAO-Bs improve, but don't slow, PD

Monoamine oxidase-B inhibitors improve symptoms in early Parkinson's disease but do not appear to slow disease progression, a Cochrane Review has concluded.

The researchers reviewed 10 trials that looked at MAO-B inhibitors in patients with early PD where treatment and follow-up lasted at least one year. MAO-B inhibitors were found to have a marked levodopa-sparing effect, which was associated with a significant reduction in motor fluctuations but not dyskinesias, and the drugs did not appear to delay disease progression.

The authors conclude: "At present we do not feel these drugs can be recommended for routine use in the treatment of early Parkinson's disease but further randomised controlled trials should be carried out to clarify, in particular, their effect on deaths and motor complications."

For more information:

www.thecochranelibrary.com

Scriptlines

Medocodene

Schwarz Pharma has extended its Medocodene range with the introduction of an effervescent variant.

Containing paracetamol 500mg and codeine phosphate hemihydrate 30mg, the tablets are indicated for the relief of severe pain in patients aged over 12 years. Each effervescent tablet contains 312.9mg sodium and 25mg aspartame so care should be taken when used by sodium-restricted patients or those with phenylketonuria. Medocodene was previously only available in packs of 100 capsules.

Price: 90 tablets £7.94

Pip code: 318-4371
Schwarz Pharma Ltd
Tel: 01494 797500

Convacare wipes

ConvaTec has launched two types of wipes in its Convacare range.

According to the company, Convacare Protective Barrier Wipes help protect against the skin problems associated with stomas, combat adhesive build-up and allow moisture to escape. Alcohol-free Convatec Adhesive Remover Wipes are said to remove tape, wafer and adhesive residues and have a citrus fragrance. Both products are *Drug Tariff* listed.

Price: £17.00

Pack size: 100
Pip code: Adhesive wipes 318-1542, protective wipes 318-1559
ConvaTec Ltd
Tel: 01895 628400

Cancer drugs

Irinotecan and oxaliplatin may be used as first line treatment for patients with advanced colorectal cancer, says NICE.

Following a review of the latest evidence, the organisation has extended the guidance it originally issued in March 2002. For advanced colorectal cancer, irinotecan may be used in combination with 5-fluorouracil (5-FU) and folinic acid (FA) as first line therapy, or alone in subsequent therapy, and oxaliplatin may be used with 5-FU and FA as first line or subsequent therapy. Although reviewed at the same time, NICE says the use of raltitrexed should be restricted to studies.

For more information:

www.nice.org.uk/TA093

Multiclix

Multiclix lancets, to accompany the finger pricking device of the same name, have been included in September's Drug Tariff. The Multiclix device is only available as part of Roche Diagnostics' new Aviva blood glucose meter.

Price: 204 lancets £8.67 ex VAT

Pip code: 317-1220
Roche Diagnostics Ltd
Tel: 01273 480444

Napp drugs

Napp Pharmaceuticals has announced the discontinuation of Phyllocontin Paediatric Continus (aminophylline hydrate), Imazin XL and Imazin XL Forte (isosorbide mononitrate plus aspirin) tablets with immediate effect.

The company says current stocks are likely to be exhausted by the end of September. Phyllocontin Continus and Phyllocontin Forte Continus tablets remain available.

For more information:

Napp Pharmaceuticals Ltd
Tel: 01223 424444

Ease bloating with WindSetlers

WindSetlers are new easy-to-swallow gel capsules for fast relief from bloating and trapped wind.

The capsules contain activated dimeticone to break down air bubbles and are free from calcium and sorbitol, which the company says can cause more trapped gases.

The launch is being supported by a £1 million TV campaign which will run from September until January, complemented by a PR campaign.

Edward Round, group product manager at Thornton & Ross, said: "Some 87 per cent of consumers surveyed told us that when feeling bloated and suffering from the pain of trapped wind, they prefer a product which is easy to swallow and does not require chewing so the potential for this product in pharmacy is immense."

Price: £1.25 for 8 or £3.49 for 24

Thornton & Ross
Tel: 01484 842217

Gaviscon Cool in handy pack

Gaviscon Cool tablets are now available in a handy pack, making it easier to carry around. The sleek, contemporary pack will hold 12 or 16 tablets and is shipped in shelf-ready packaging for maximum impact.

Price: 12 pack £1.99, 16 pack £2.65

Reckitt Benckiser
Tel: 01482 326151

Real Quit is back

Niquitin CQ is being backed by a £3 million campaign this autumn.

The successful Real Quit campaign is returning and the new advertisement features Lorraine, the original quitter from the first Real Quit campaign. The new advert sees Lorraine, who quit smoking a year ago, embark on a new challenge. She is featured trekking Mount Kilimanjaro to raise money for a children's charity, something she couldn't have done before giving up smoking.

The new campaign begins in September and will feature on TV, radio and in the press.

For more information:

GlaxoSmithkline
Tel: 020 8047 5000

Supplements made easy

Healthy Choices is a new range of supplements designed to encourage customers to try natural remedies.

"It's a range of lifestyle products designed to make shopping for health food supplements far easier for the less informed public," says managing director Chris Keeble.

The range includes six products. Busy Lifestyle contains dextrose, green tea extract, fructose and coffee extract. Healthy Joints includes vitamin C, glucosamine sulphate, chondriotin and manganese. Immune Defence contains vitamins E and C, zinc, iron, green tea and citrus bioflavanoids. Menopause includes a range of vitamins and supplements plus boron, chromium and soy isoflavones. Healthy Eyes contains a range of vitamins and supplements plus bilberry and lutein. Female Health also includes a range of vitamins and supplements as well as green tea, kelp, chromium and folic acid.

Leaflets for retailers and consumers are available as well as a health wheel to help customers choose the right product for their needs.

Price: £2.99 for one month's supply

Natrahealth
Tel: 01889 271333

Haliborange Omega-3 on TV

Haliborange Omega-3 for Kids is being supported by television advertising this autumn as part of the £2.5 million campaign for the brand.

Running from September 5 until the end of October, the "Fintastic" advert is based in an underwater scene and features an orange fish character. The TV advertising will be backed up by a PR programme and in-store promotions.

For more information:

Seven Seas
Tel: 01482 375234

Relief for baby snuffles

Baby Nose-Clear nasal aspirator for helping relieve nasal congestion in babies is now being distributed by EMT Healthcare. The product is being featured in the *Bounty Baby Guide* and details are being circulated to health professionals.

For more information:

EMT Healthcare
Tel: 0115 849 7700

Beechams voted top remedy

Beechams has been voted "most trusted brand" in the cough and cold remedy category by the *Reader's Digest* Trusted Brand survey. The survey found that Beechams is used by 79 per cent of those questioned and obtained a 22 per cent share of votes in its category.

For more information:

GSK Consumer Healthcare
Tel: 0800 100 9997

Simple Guides to inform patients

A new series of patient information books is being launched through pharmacies. Called *The Best Medicine Simple Guides*, they have been written by the medical publisher CSF and the Patients' Association. There are six titles in the series, with more to come next year. The titles on offer include: *A Simple Guide to Asthma, Back Pain, Blood Pressure, Cholesterol, Depression and Type 2 diabetes.*

If pharmacists stock the range an information pack will be sent to neighbouring surgeries, which will include the details of local stockists.

Each title costs £5.95. A starter pack of six copies of each title, six clip strips and a pack of patient information leaflets is £144.

For more information:

CSF Medical Communications Ltd
Tel: 01993 885399

Lyclear head lice info for schools

The maker of Lyclear has produced an information pack on head lice designed for use in schools to increase awareness of the importance of regular detection combing and prompt treatment.

The pack aims to educate parents and teachers about head lice, confirming an infection and the treatment options available. The role of the pharmacist is also promoted in the pack.

Schools are being contacted by e-mail and invited to send for the free support materials.

For more information:

Chefaro
Tel: 01480 421800

New Nurofen TV campaign

Nurofen tablets and caplets are being backed by a new television campaign which will run during September and October. Entitled 'Stream of Consciousness: Car' the advert depicts a woman sitting in her car in a car park at night suffering from a headache and uses innovative techniques to demonstrate the pain she is in, then the relief after taking Nurofen.

For more information:

Crookes Healthcare
Tel: 0115 953 9922

Avent adds intelligent breast pumps

Avent is introducing two more electronic breast pumps to its Isis range this autumn.

The Isis iQ Duo Twin electronic pump is designed for mums with twins or more, mothers of premature babies or those who need to express milk fast during breaks at work. The Isis iQ Uno hand-held electronic pump is the first hospital grade hand-held battery pump and is convenient to use wherever you are.

Both pumps have the soft let-down massage cushion and sensitive control, with the addition of an electronic 'brain'. This allows mums to personalise their own pumping rhythm thanks to digital technology that allows variable fingertip control. As the control handle is depressed, electronic signals are sent to the microprocessor to memorise the suction speed and interval between each depression. When the control button is pressed, the pump takes over until told to change.

The Duo pump comes with a travel bag, two breast pumps, milk storage containers, cool packs, Thinsulate carriers and manual parts so the pump can be used when power isn't available.

The Uno pump comes with milk storage containers, battery pack and mains power lead.

Price: Duo £250, Uno £85

Cannon Avent
Tel: 01787 267000

Vesagex Heelbalm updates image

Vesagex Heelbalm has been given a contemporary new look with eye-catching new packaging. The product is also now available in both 50g and 100g tubes.

Versagex Heelbalm contains urea (25 per cent), allantoin and natural peppermint oil which chemically break down hard areas of skin and leave skin soft and refreshed.

Price: 50g £4.99, 100g £7.95

Herbal Concepts, tel: 01525 292345

In brief

Rescue Cream gets support

Nelsons is backing its Rescue Cream with a high profile campaign this autumn which will educate consumers about the effects of stress on their skin. It will include new point of sale material and leaflets, online advertising, consumer promotions and directed marketing.

Price: 30g £4.15, 50g £5.75

Nelsonbach
Tel: 0800 289515

Transform your skin

Transderma C is a new treatment said to boost the skin's collagen production, giving younger looking skin. The serum contains a pure solution of vitamin C that is said to be quickly absorbed into the dermis to help increase production of collagen. It's free from perfume, alcohol and preservatives, so is kind to skin.

Price: £89 for 30ml bottle

Dermaskincare
Tel: 0845-644 3994

Correct price for Sea Pearls

We gave out the wrong price for Sea Pearls natural sponge tampons in our August 13 issue. The correct price is £7.99 for two sponges.

For more information:

Pure Balance
Tel: 01787 371527

TV trex

Bassett's Soft & Chewy Vitamins range: GMTV, Sat

Canesten Duo TV: All areas except CTV, M, CAR

Germaloids: C4

Kool 'n Soothe Migraine, Kool 'n Soothe Kids: GMTV

Ribena: All areas except U, CTV, GMTV

TENA Lady: All areas except U, CTV, LWT, GMTV

TENA Pants Discreet: All areas except U, CTV, LWT, GMTV

PharmaSite for next week: Solpadeine – Window, **Care Summer skincare range** – In-store, **Pepto-Bismol** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Potty parties help train toddlers

Kimberly-Clark is supporting its Huggies Pull-Ups with See 'n Learn pictures with a potty training campaign. This will involve a series of See 'n' Learn Potty Parties throughout the UK at pre-schools, nurseries and health centres.

Parents will receive a *Guide to Potty Training*. A TV campaign is highlighting the new pull-ups and offers parents a free DVD on potty training. There's also point of sale support for retailers.

The See 'n' Learn Pull-Ups have graphics which disappear when the child wets, helping them to understand the difference between wet and dry.

For more information:

Kimberly-Clark, tel: 01732 594000

Cyber Princess theme for winter

Cyber Princess is the theme for L'Oréal's new winter make-up look which uses metallic gold and silver blended with grey and blue.

Eyes are enhanced with Color Appeal Platinum in Pure Gold, Real Silver and Aurora Grey. Lips are glossy in Glam Shine Cream in X-Treme Brown combined with Glam Shine Holographic in Gold Toffee. To finish the look, nails are bold burgundy shade 502.

Price: Color Appeal eyeshadows £4.99, Glam Shine Cream £7.99, Glam Shine Holographic £6.99, Resist & Shine nail colour £4.99

L'Oréal
Tel: 0161 655 1400

Grooming for success

The blurring of gender roles is one of the driving forces behind the western male's interest in personal care, a market report says.

It's not necessarily a case of machismo v metrosexuality, but almost as many men as women say they are increasingly spending time on their personal appearance.

These figures are presented in the latest report by independent market analysts Datamonitor, which predicts that men's usage of personal care products in Europe and the USA will grow from $31.6 billion in 2003 to $37.6bn in 2008.

Its report, *Evolution of Global Consumer Trends*, sets out 10 trends influencing consumer buying behaviour, and says that with polarised values and behaviours characterising male lives, 'role anxiety' is becoming more apparent.

"Men are less certain of their roles, their careers and their relationship to family as they reconcile effeminate values with older fashioned macho values. It is vital that marketers avoid taking a one-dimensional perspective when targeting specific genders, especially males," says Daniel Bone, a consumer market analyst and the study's author.

Among European and US men, the report found that 73 per cent of men, compared to 72 per cent of women, felt that spending time on personal appearance was 'important' or 'very important' to them. Across all countries, 47 per cent of male correspondents indicated they spent more time on their personal appearance over the course of 2003-04, compared to 51 per cent of females.

This change in behaviour, towards less macho values being the norm, runs alongside women entering traditionally male domains such as the workplace. There is a growing trend towards individuals possessing egalitarian values with regard to gender roles. Datamonitor believes: "Men, especially the younger generation, are becoming more experimental when it comes to trying out new products and grooming practices and this offers an array of opportunities for 'on trend' product development." In other words, manufacturers should be developing male-specific brands in the grooming arena. One example of such a move is the launch of L'Oreal's Men's Expert range of anti-ageing line products incorporating its Active Defense System.

Nevertheless, traditionally male concepts such as cars and beer will still have a place as men don't necessarily want to be seen to be trying too hard to adopt metrosexual qualities, especially when many die-hard macho males are still holding the feminisation of society in contempt, suggests Mr Bone.

Hence, there is a need to adjust the marketing mix of male grooming products, so that the spectrum of male values can be catered for. An example comes from the USA, where O'Keeffe's Working Hands Handcreme, deemed a "typical metrosexual product", is seeking acceptance among the more macho males by being sold through hardware and DIY centres.

However, a taboo remains: Datamonitor says it has not included make-up in its figures "as male usage is negligible". It could be that by spending £1,800 on make-up the Prime Minister was just ahead of his time.

Evolution of Global Consumer Trends is available from Datamonitor on 020 7675 7202.

Men's usage of personal care by product market, Europe and USA 2003-08

Market	2003 (US$m)	2008 (US$m)	CAGR 2003-08 (%)
Skincare	1,434	1,725	3.8
Personal hygiene	21,545	25,586	3.5
Haircare	6,405	7,722	3.8
Fragrances	2,172	2,568	3.4
Overall	31,557	37,602	3.6

You are developing a service and what to charge for it, but how do you persuade those in charge of the purse strings that your proposal is worthy of consideration? Peter Gaylard looks at how you talk the talk

The art of **influencing**

At last, pharmacy has been recognised by 'the powers that be' as competent and well-placed enough within the community to provide more than just a dispensing service.

For the first time the pharmacy contract framework in England and Wales provides a basis, under enhanced services, for the development of new – and the transfer of existing – NHS services to community pharmacy.

This is an amazing opportunity for community pharmacy to fulfil its true potential. What could be easier – after all, many new services have already been extensively piloted, and we know that the patient demand is there. What could possibly stop us? All we have to do is convince our local primary care organisation (PCO) to commission and fund the service from its seemingly overstretched budget. Let's just make an appointment and go tell the PCO team all about it. By the end of the meeting the chances are they will say: "Very interesting but we don't have the money," or something very similar.

In this brave new world the successful introduction of new community pharmacy-based services will be more dependent on our ability to influence the key parties than the actual value and quality of the service to be provided.

So, how do we go about improving our ability to influence? The first thing to recognise is that the ability to influence is actually a skill set, founded upon knowledge and attitude. Both the skill set and the knowledge can be learned. With practice and mentoring, these skills can also help us in many different aspects of our business life. Developing a positive, but not over-assertive attitude is down to you. However, having a grasp of the skill set will help confidence and will certainly improve the chance of success.

'Structured influencing' is based on the principle that 'If we don't know where we are going or how we intend to get there, what are our chances of reaching our destination?' By understanding the structure and undertaking the necessary preliminary work, we will gain a basic understanding of what we have to do to achieve our goal and we will have a means by which to measure progress.

The main elements of the structure

The starting point for structured influencing is the acquisition of relevant background information through appropriate research. This should be used to construct a sound goal and succinct pre-visit objectives. These objectives can then be used to develop an opening strategy that will encourage early closing opportunities.

Objections will undoubtedly be encountered and these will need to be handled and a committal and recall opportunities sought. Finally, throughout the structure there should be appropriate use of features, advantages and benefits together with an understanding of body language. As with a lot of things in life that you meet for the first time, this overview of the structure will undoubtedly include terminology that is unclear.

However, before exploring some of the elements of the structure in greater detail, it is important from the outset to recognise a few things. Firstly, communication is a two-way interaction – there is nothing like stating the obvious – but I'll bet that you, like me, can think of conversations when it has been difficult to get a word in edgeways. Something happens to people when they feel they have something to say. Enthusiasm takes over and you just can't shut them up. Unfortunately, despite the evident enthusiasm, the recipient of this tirade usually just switches off.

Secondly, the use of a structure is not meant to introduce rigidity and an uncompromising approach to influence. The structure is the road map. Once we know the route to our destination it's quite acceptable to make deviations in order to accommodate the dynamic nature of two-way communication, while still ending up where we want to be.

Finally, it is important to understand why people make the decision to 'buy' a concept, commodity or service. Generally speaking 'customers' are in a state of inertia and are resistant to change. It is up to the influencer to establish what will inspire that change. The simple answer is 'need'; unfortunately that is where the simplicity ends.

Buying needs are often based on an emotional subtext like status, confidence, the desire to be liked or be respected, and the only way to establish an individual's subtext is through research, the appropriate use of questions and watching for buying signals. As an example, a person does not buy a car because it is red. They buy the car because in some way the transaction will make them feel good about themselves. What is a certainty is that customers buy for their own reasons, not for yours.

Although the customer's reason for buying a service is need, their decision to buy that service from us will be affected by a number of other factors of which 'trust' is arguably the most important.

Trust is of particular importance to a customer who is intending to buy a high-priced item, such as a new pharmacy service. To build the necessary trust will require perhaps three or more meetings with the same individual within the PCO. This makes the need for the generation of opportunities to revisit the customer paramount.

Background research

Knowledge is power and the purpose of background research is to provide you with the necessary knowledge to better understand the needs of the PCO, the individual you are seeing and the local population targeted for your proposed service.

The more relevant the information you can discover, the stronger your case will be. Information to look for might include market size and service specifications, available from a variety of pharmacy and primary care sources.

This article can help in the following CPD competencies: G2a, G2b, G2i, G2j.
A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Terminology

Open and closed questions
Open questions use 'who', 'what', 'where', 'when', 'why' or 'how' and therefore cannot be answered with a simple 'yes' or 'no', whereas closed questions use 'will' or 'would' with the specific aim of prompting a yes or no response.

Committal
Final agreement from the customer to the introduction of our service, gained by the use of a 'closed' question.

Recall opportunity
An opportunity that arises within the meeting/discussion that provides the chance for a further meeting with the customer. For example, requesting a further visit to answer a particular information seeking question. Bear in mind on average it takes three visits before a customer will agree to a committal.

Features, advantages and benefits
Feature – is a characteristic of an object or service.
Advantage – what the feature can be used for.
Benefit – the emotional response generated by the advantage.

Setting pre-meeting objectives

The ability to effectively measure our level of success will be determined by our understanding of what we want to achieve in the meeting. Is the meeting just to introduce a new potential pharmacy service to the PCO, or do we want the result to be the introduction of this service by a given date, to an agreed standard and at a mutually acceptable price?

It is essential that we first of all understand and define our overall goal, ie exactly what it is we want to achieve. Our objectives then become the stepping stones to attaining this overall goal.

Although just about everyone finds the writing of objectives to be tedious, in reality if done properly they are worth their weight in gold. Why? Because in writing a well crafted objective, we have to give consideration to what it is we actually want to achieve in the meeting and whether our aspirations are reasonable and achievable. Once we have our objectives, these should provide the context for our influencing structure and after the meeting the objectives give us parameters to measure our level of success.

Traditionally, most tutors when dealing with the writing of objectives use the pneumonic SMART. However, because we are dealing with influencing a third party it is important for our objectives also to be behavioural. In other words, the objective should require a positive change of behaviour in the third party.

Objectives should be judged on whether they are SMART Bs:

- Specific
- Measurable
- Achievable
- Relevant
- Time limited
- Behavioural

The Opening

Once we have completed the normal introductory pleasantries at the start of our meeting with the PCO we should move into our opening. The direction and nature of our opening statement should be determined by our pre-meeting objectives. There are a number of types of opening that we could employ dependent on the perceived situation and our objectives. But why plan an opening?

Knowing what we are going to say to start with and where this is likely to lead the conversation will improve confidence, ensure correct direction and reduce the risk of rejection.

When constructing a pertinent opening we need to consider a number of attributes:

- relevance to the customer
- interest for the customer
- creates customer involvement
- identifies customer needs.

Of the different opening techniques perhaps one of those most commonly used is 'stating the case', in which we give a concise overview of the background to our proposition and end by asking an open question. Such statements can include bold claims to gain the customer's attention but these should always be true. We should not fall into the trap of letting our opening statement just ramble on, because if this happens then the customer will just switch off.

To find out more about Structured Influencing contact *peter@synapseconsulting.co.uk*

The second part of this article will deal with some of the other elements of the structure with particular emphasis on what seems to be everyone's nightmare – the handling of objections.

You are not **alone**

With the end of the pharmacy contract transition period drawing nigh, Anna Goldie talks to pharmacists to find out how they are coping with enhanced services, premises and paperwork

Andrea Standing
locum, Lloydspharmacy, Doncaster

The new contract has been all too much at once and we don't have time to go on courses. We don't have enough resources, like computers or space, to implement the new contract fully. Our PCT has been very helpful, but although the new premises look lovely on paper I can't imagine how they will do them.

I think you would have to demolish all of the premises in the area and start again. I work in and around the area and wherever I work I don't see the facilities needed.

Hannan Alfanek
pharmacist, Boots, Market Place, Doncaster Central

THE NEW CONTRACT

Although the new contract is very exciting, at the moment I am training a pharmacy assistant, a student and pre-reg all at the same time so I don't have time for extra services. And I have to do a medicines use review on my own; we need the support and cover to be able to provide these things. Instead we have to take a lot of work home with us.

I can't get in touch with my PCT without approval from Boots, so there is no personal involvement.

SERVICES

It is unfair that some pharmacists are able to provide services because they are not busy and they can approach GPs about enhanced services and training. We just don't have the time to do that. We don't have enough time or locums to provide the services that we would like to, like cholesterol testing.

Katie Webb
partner contractor, Gaskell & Webb, Wheatley Hills, Doncaster Central

THE NEW CONTRACT

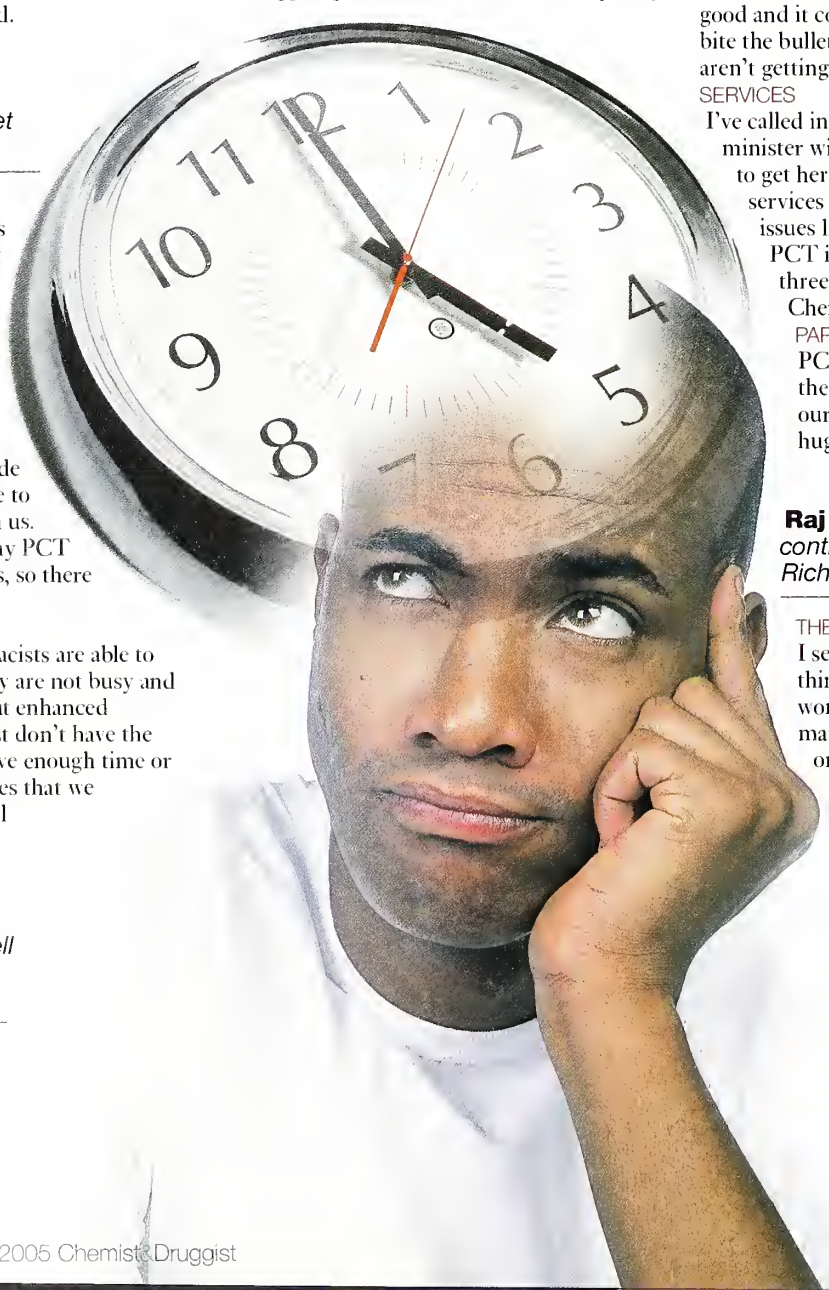
Everybody's struggling with the new contract. There just seems so much to do and read to meet what's required. My main help has been with suppliers, who are Mawdsley Brooks and UniChem, and who have both produced literature to help people set up consultation rooms and have even offered financial help.

The LPC has also been very good and they have produced a month-by-month checklist of your progress with the changes required.

We don't have a particularly close relationship with the PCT and with certain things like signposting and waste disposal we find we are waiting for direction from them.

SERVICES

Our biggest problem is that we are a very busy small, independent pharmacy and time management is very difficult. We've been dubious as to whether we'll be able to provide the time, space and funds to provide extra services. If it carries on it will only get worse in terms of patient care.



John Davey
contractor, five pharmacies in Liverpool

THE NEW CONTRACT

The new contract is a real opportunity. It's good and it could be even better if pharmacists bite the bullet and get the training, but we aren't getting the resources and time for it.

SERVICES

I've called in on Jane Kennedy [health minister with responsibility for pharmacy] to get her advice and support about extra services and she has been aware of local issues like smoking cessation. But the PCT is slow. It's taken them two or three years to organise a Care at the Chemist scheme.

PAPERWORK

PCTs want us to be accountable to them but it means we are policing ourselves for them, which takes a huge amount of time and effort.

Raj Rohilla
contractor, Richmond Pharmacy, Richmond

THE NEW CONTRACT

I see the new contract as a positive thing. It will widen our variety of work and improve our profit margins; however, it has all come in one go and it's an overwhelming workload. I have an enormous amount of paperwork to meet the demands made by the PCT.

PAPERWORK

If we had electronic records, like spreadsheets, we could easily send them to the PCT. For all the services we are providing 10–15 pieces of paper to go with it and the PCT have to deal with it at the other end.

PCT

I have a few pharmacies in different areas and there is a wide variety of understanding between the PCTs about the same thing.

"The PCTs have all been very helpful when I've needed it, but some members of the PCT don't have the experience necessary for the job"

Whether it's waste disposal or needle exchanges, we have to go through a different procedure for each PCT.

The PCTs have all been very helpful when I've needed it, but some members don't have the experience necessary for the job, which leads to the misinterpretation of the contract. In health authority days practice was universal across the UK.

NHS LIFT

One concern I have is the LIFT Centres. Local pharmacists felt cornered to join the centres and found if they didn't then the contract would go to a multiple. They cost a lot of money to run for very little return. It's the same with the OFT review. I think there's something political about it. It doesn't advantage the smaller pharmacist and multiples have found loopholes that they can take advantage of.

PREMISES

Consultation rooms are also something I feel strongly about. Multiples are getting away with designs that don't provide the confidentiality that smaller pharmacies couldn't.

Peter Cattee

Chesterfield, and contractor with 90 pharmacies in the Midlands and the North East

THE NEW CONTRACT

There is a lot of goodwill surrounding the new contract and people are trying really hard but the major problem is reorganising the business while still doing pharmacy. I really hope that come October extra demands aren't made on people and PCTs aren't too heavy handed when it comes to policing pharmacies.

PAPERWORK

Keeping track of payments is one of the most difficult things. Every PCT has a different way of doing it so we have had to hire a new member of staff just to deal with payments. Payments need to be universal across the country, rather than us dealing with 16 or 17 PCTs as we are now.

PCT

Some PCTs have been really helpful but some need to decide whether they are commissioners or providers because I don't think they can always do both and I think their true nature is commissioning.

Our smoking cessation scheme has been really successful and the PCT would not have met its QOF target if they hadn't used the services of community pharmacists.

NHS LIFT

In some areas it's a solution trying to find a problem. OFT reviews are happening far too early.

Roger King

secretary, Dorset LPC and contractor, Lytchett pharmacy

THE NEW CONTRACT

We have been working slowly but surely towards the new contract, so we are not inundated with a very heavy workload. We moved into brand new premises with consultation rooms and patients love it and take advantage of the services we are offering.

PCT

Our PCT is very switched on. They've held meetings for us and have an excellent clinical governance team.

FUNDING

It's still early days and it remains to be seen if we'll get all the remuneration from the category M list. What we're losing on prices we're making up on additional fees and allowances.

Mukesh Lad

manager, Pickfords, Leicester

THE NEW CONTRACT

Initially the new contract has been overwhelming. Time management is very difficult, pressures like clinical governance and audits are big enough without having to deal with commercial and business pressures too. We're not all going to be able climb a mountain like that, but instead we're taking a step at a time.

PAPERWORK

There has been a fundamental shift in what we are expected to do. We were trained as pharmacists not bureaucrats, doctors have traditionally had receptionists to deal with paperwork, but it's expensive for a small operator to train or hire staff to do it. Saying that, the PCT has been understanding about the changes and have provided courses to help us deal with them.

Dr Hooman Ghalamkari MBE

contractor, DG Pharmacy, mobility and healthcare, Worcester

PAPERWORK

We are going to be deluged by admin. We're not used to paperwork and we're not getting paid to do it. I think IT is the key to this. We currently have to duplicate everything, which is often needless because we have details on the PMR. We need designed forms with templates. The new contract has really put pharmacy on the agenda at the PCT and they are generally very supportive but they don't have an everyday understanding of community pharmacy and the difficulty of fitting in clinical practice and admin.

NHS LIFT

My problem with NHS LIFT is that it will go down the private finance route. A PFI will offer the lease of the premises at a huge premium, and the contract will follow. Only big multiples will be able to afford it.

Riaz Esmail

contractor, Fairview Pharmacy, Edgware, Middlesex

PREMISES

The operating procedure in pharmacy will have to change. The point at which patients receive medicines is very important now because they might need an MUR. We are fitting computer points on the counter with booths to offer privacy to patients. We are also working out how we'll separate inflowing and outflowing prescriptions. IT solutions are another thing we're looking at because paper-based audits will be difficult.

PCT

So far the PCT has been fairly receptive but we have done everything off our own back and they too are busy with the new contract. We all need to take the long view and work out how we are going to provide our own resources. Fitness to practise is a problem too. It's good that we're being asked to be accountable but there aren't the resources to provide all the services. They seem to be working in a financial vacuum.

OFT REVIEWS

OFT is really a problem. On the one hand we are trying to take bold steps towards patient services but then we found out a local supermarket pharmacy is applying for a 168 hour contract. The new contract is still very much item orientated, which we get paid for so the number of items we sell decrease the services we can provide decrease accordingly. If the supermarkets win the contract the number of items we sell will go down and will local services. Supermarkets have a stranglehold – it really hasn't been thought properly.

Being at the top of the tree is a challenge for all, especially in the new NHS, says Anne Adams in the second of our series of articles looking at leadership skills

Look out – your NHS needs you

"Leadership creeps up on you. Whatever leadership means to you, unlike the promotion to manager, it arrives, not with a big bang on a particular day, but almost unnoticed. Leadership creeps up on us because we may not notice the extent of the difference it makes" (Pedlar, Burgoyne, Boydell).

Pharmacy particularly needs good leadership considering the challenges of the new community pharmacy contract. Power, responsibility and resources have been devolved to local level within the NHS, and more and more pharmacists are finding that they need to think and act strategically to place themselves where they can hear and be heard, and conduct themselves in a way that they will be listened to.

We considered what leadership is in the first article in this series (*C&D, August 13, p26–27*). There are many theories. It is practised at many levels, in different contexts and in different styles. It is an art as well as a science and has been likened to being yourself, only with skill. Most of us would not be able to comprehensively describe leadership but would be able to recognise it when we saw it.

Actually most of us, when pushed to do so, would probably describe the 'great man/woman' style of leadership. We might think of a prime minister or a manager that we respected, perhaps a great historical figure and not necessarily someone using their leadership skills for the greater good. We might equate leadership with management; it is not exactly the same thing, as we saw in the previous article.

Many managers are also leaders; this might be what makes a good manager. Some leaders have no formal management responsibility over you but you would still follow them, such as the pharmacist working across town whose opinion you value. Of course, it doesn't even have to be a pharmacist.

We cannot rise to the leadership challenge if we don't recognise leadership in its diverse forms, and even if we do, how do we get to know what to do to embrace it? Do you understand the part that leadership plays in your personal practice? Who leads you? Who do you lead? Are you part of leadership or not? If you are not leading then what are you doing? – supporting, resisting, bystanding, undermining, cheerleading, ... or what?

"Leadership involves everyone; and everyone involved is doing something" (Pedlar et al).

Leadership development

The NHS leadership development movement is not only about developing senior leaders but also about each person taking responsibility for the part of the service over which they have control, and being accountable for making it better (distributed leadership or leadership at every level). This should improve the quality of service and encourage innovation.

At its logical conclusion, this could mean an individual pharmacist taking the lead on changing the way (s)he practises the profession which influences others to adopt this way of working. It could be about developing skill mix, and putting leadership skill building blocks into place throughout a career, succession planning, innovating or working to spread innovation. It could be about great practice in any sphere.

Remembering the patient, it could be about concordance; developing the capacity of patients to take the lead on decisions about their own healthcare.

We cannot rise to the leadership challenge if we don't recognise leadership in its diverse forms

This article can help in the following CPD competencies: G1n, G2a, G2g. A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

Working with other professionals

To what extent have pharmacists been involved in, or kept up with the NHS leadership development agenda, particularly as we now arguably have closer ties with the NHS through the new community pharmacy contracts and, for example, the public health agenda?

Do we understand the rest of the NHS's 'take' on leadership and can we fit in? Do we speak the same language? What management and leadership skills can we bring to and learn from, the NHS? How well can we work and employ our leadership skills across sectors and organisational boundaries in networks and teams in order to maximise the opportunities presented by the new community pharmacy contracts and possibly to minimise any threats? You will probably find that a different subset of skills is needed to work in the latter to those required in your usual work setting.

Can we recognise when to use which approach and how good are we at each? Professionals are notoriously difficult to manage but perhaps a little easier to lead. We work to our own code of ethics, which allows and encourages us to use our professional judgement that can result in us challenging authority.

We may have established our place in our work hierarchy but what happens when we find that we have to work with our colleagues in primary or secondary care who are equally 'difficult'? Do we resist; do we try to manage situations where we can only hope to achieve a realistic result by leading others, and, of course, just because we want to lead, it doesn't automatically follow that we will be allowed by our potential followers to do so.

A key part of the leadership process is knowing when to be a follower and when to allow others to lead.

What can you do now?

It is now generally agreed that leadership skills can be learnt as part of an ongoing process such as continuing professional development. So, where would be a good place to start?

Taking part in a leadership development programme would be useful but we could all start developing our skills as part of our CPD now. The NHS Leadership Qualities Framework,[1] which can be found at *www.nhsleadership qualties.nhs.uk*, is the framework favoured by the NHS.

It is a set of 15 qualities, which set the standard for outstanding leadership to which any leader, at any level in the NHS, should aspire. Beneath each quality are competence levels and with each quality comes an explanatory paragraph, linking it to others.

Identifying your skills development needs and linking this to your personal development plan will be a useful beginning. Asking those around you at work or at home for feedback on your skills could be invaluable, giving you an external view of how you are perceived. This can be reflected on and fed back into the CPD process.

Developing your leadership skills and those of the people around you enables you to devise effective strategies and services and gives you the 'people skills' to put them into practice. It isn't everyone that will be able or willing to develop into a marvellous senior leader but everyone can be better than they already are.

Your personal qualities should show that you are competent and honest in your dealings with others and will inspire trust in those around you. Being highly competent in each of these areas will also help you deal with the ups and downs of taking the lead, the demands and stresses of being at the leading edge.

The outer portion of the framework is divided into two sections setting direction and delivering the service. This cannot be thought of as equivalent to strategic and operational leadership respectively as, for example, on closer examination of the 'doughnut', effective and strategic influencing appears under delivering the service whereas you might expect it to come under setting direction.

In both of these areas transactional and transformational leadership are important but here we are particularly concentrating on transformational leadership. Transactional leadership can be seen as keeping an existing service running smoothly, or managing it and transformational leadership producing a change in a way of working. Both are very important.

Beginning the process of looking at your leadership skills is very important and should run in parallel to the changes you are planning for your services.

How to use the framework

Individuals, organisations and teams can use the framework for:

- Defining and shaping leadership roles and profiles
- Professional and personal development
- Recruitment and selection
- Succession planning
- Performance management
- Appraising performance
- Career mapping and planning

Individuals can use the framework as part of their continuing professional development to:

- Understand the leadership challenge of their current and previous roles
- Understand the leadership elements and qualities required for a role to which they aspire
- Identify the gap which may exist between their current capabilities and the requirements of the next role
- Formulate a personal development plan

Organisations and teams (including pharmacy development groups) can:

- Assess their joint leadership capacity and capability
- Identify the range of strengths within teams
- Identify areas for collective and individual development
- Benchmark performance against other organisations
- Develop organisational and team strategies for leadership

www.nhsleadershipqualities.nhs.uk

For further information on rising to the leadership challenge contact Anne Adams at *anne.adams@rpsgb.org* or your training manager.

Our next article in the series will examine how we visualise the future and communicate our vision in a motivational, empowering manner.

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Anne Adams is the head of professional leadership at the Royal Pharmaceutical Society.

This series of leadership articles is being put on www.dotpharmacy.com (click on "features") as each article is published.

Friends and **family**

HI Weldricks has a strong family ethos and is committed to community healthcare. Jane Ellis reports

Superintendent pharmacist Richard Wells (below) and training manager Marilyn Jones (below right) are part of the driving force behind the family run company

Ron Alcock founded the independent multiple pharmacy group HI Weldricks in Hatfield, Doncaster in 1967. He had qualified as a pharmacist three years earlier from the Sunderland School of Pharmacy. His interest in pharmacy started in childhood when he helped out in his grandmother's pharmacy in the centre of Doncaster.

Not content with just one shop, however, Mr Alcock was keen to expand and by 1984 had nine outlets, which traded under the HI Weldricks name.

The firm remains in the control of the Alcock family to this day. Ron Alcock is still managing director. His son Christopher is business development director. The management team also includes superintendent pharmacist Richard Wells and operations director David Vanns. Together they are the motivational force behind the company.

There are now 47 branches throughout Doncaster, Rotherham, Sheffield, Barnsley and Lincolnshire. In total there are 450 employees, of which 49 are pharmacists. They are all highly motivated and committed individuals.

Training manager Marilyn Jones says there is a strong family ethos at the company. "They care for the people who work for them. There is a good forward-thinking management team which provides a pleasant working environment," she says.

HI Weldricks also has a place in the wider pharmacy sector and the South Yorkshire community and has won several business awards for its performance and quality of training. It was also the first UK pharmacy to reach the Investor in People standard in 1993 and has ISO 9001.

"We're proud of our reputation," says Ms Jones. "People come to work for us because they know of our reputation and they stay because they like being part of a family-run operation. All of our pharmacists are known personally and all this goes a long way to making our people content."

Weldricks separates its retailing and pharmacy services, freeing pharmacists to use their skills in the dispensary rather than in the buying, retailing or housekeeping operations. There is always support at both branch and head office. Pharmacists can work with GP practices on advising on prescribing and running clinics. If they are interested in training, the company encourages them to become pre-reg tutors and get involved in in-house training. It will also provide funding for clinical diplomas and MSc degrees to ensure that its staff are well qualified and supported in their development.

It is important to Weldricks that its pharmacists do not have to compromise their own opinions or individuality. It says it promotes an atmosphere where ideas can be heard and problems shared. In essence the company is committed to community healthcare. As Christopher Alcock says: "We believe that healthcare services should be readily available in the local communities where people live."

> **"There is a good forward-thinking management team"**

The company has established some effective training and development processes in its pursuit of the Investment in People standard. The best measurement of this is the number of staff who progress through the company.

Richard Wells, for example, started as a branch pharmacist and has moved up through the ranks to superintendent pharmacist and the management team. He is also known in the locality for his work with Doncaster LPC and Doncaster West PCT.

Operations director David Vanns is general secretary of the Association of Independent Multiple Pharmacies (AIMp) and takes a proactive role in community pharmacy generally.

Ms Jones says there are plenty of opportunities for pharmacists at the company. As well as working in branches, two have extended roles as teacher practitioners at the Schools of Pharmacy in Nottingham and Bradford. Others are involved in LPC work or assessing NVQs.

"We are keen that those who want to develop, do," says Ms Jones. "We give annual appraisals and look at the career path of all our pharmacists. We offer extended roles to pharmacists of various ages, from various ethnic backgrounds and of both sexes. Opportunities are there for them."

Training and development has always been a top priority. There is a purpose-built training centre at the branch support centre in Doncaster, which is where the company headquarters and warehouse are based. The company is a City & Guilds accredited training centre and runs NVQ Level 2 and 3 pharmacy services qualifications in-house. A development programme has also been written in-house and is presented by members of the management team. Bi-monthly pharmacy forums can cover a range of issues, including the new pharmacy contract. "We're happy to accommodate flexibility," adds Ms Jones. "Job share roles are also possible."

In order to plan for succession, the company runs a 12-month pre-reg programme, which had a 98 per cent success rate last year where out of eight students, five stayed with the company after qualification. "Because we're expanding, we're always actively recruiting," says Ms Jones.

For more information: www.weldricks.co.uk

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Angela Alexander demonstrates how the ubiquitous Chupa Chups prompted some lateral thinking and led to some CPD on the way

Suck it and see

Have you ever had that Da Vinci moment? The moment when all the pieces of a jigsaw start to fall into place and you finally understand the meaning of it all? For years I have pondered on the meaning of Chupa Chups. What do they mean? Is there more to them than meets the eye (or perhaps the tongue)? And more importantly, why do pharmacies sell them?

There had to be a reason why, even in pharmacies that eschew the very thought of selling confectionery, that familiar Chupa Chups unit stands proudly on the counter in prime place. In the past I've dared to question this and usually get the reply "Ah, but they're sugar-free". So that makes it all right then, does it, to place the stand in the position where our professional image should be most prominent? There had to be more to it. Working in a pharmacy recently, all my ponderings started to fall into place.

It started on a Saturday, just like any other Saturday. "Can I have a lolly?" that plaintive cry came from a small person beneath the level of the counter. "I want that one" and a hand reached up and made a grab. The whole display fell, scattering lollies across the floor. Those of you who stock Chupa Chups will know that if you don't keep the base unit full, the centre of gravity becomes too high, the porcupine becomes unstable and the resultant topple is inevitable So could this explain why so many pharmacies stock Chupa Chups; they act as a proxy measure for that crucial pharmacy activity "fill up and face up".

As I picked up the lollies I looked at that familiar Chupa Chups red and yellow logo. There was something iconic about it. When I got home that night I put my feet up and opened a magazine. There in front of me was the Chupa Chups logo again, not what I expected to find in the spring edition of the journal of *The Tate Gallery*. Reading on, I was even more astounded: the Chupa Chups logo was designed by Salvador Dali! Yes that Surrealist master played a part in the mystery. Just as Da Vinci had provided Dan Brown with the key to the Holy Grail, was Dali trying to tell us something through Chupa Chups?

"The Chupa Chups logo was designed by Salvador Dali

With the help of the internet I discovered that Salvador Dali was a friend of Enric Bernat, the originator of Chupa Chups. I also discovered that Chupa Chups, launched in 1958, were the first ever lolly designed specifically after consumer research of children. Enric Bernat had realised that when children ate sweets, they got themselves in a sticky mess, causing parents grief. The solution seemed easy: he put the sweet on top of a stick. He'd recognised a need and provided what people wanted.

When Bernat bought Granja Asturias SA, a troubled Spanish confectioner, he axed most of the company's 200 products to focus on the line of lollipops. He recognised that 80 per cent of the profits came from fewer than 20 per cent of their brands and made the brave move of killing the unprofitable brands. There was surely a message there for pharmacy. With 80 per cent of our income from the NHS side of things, why is it that the most prominent aspect of our pharmacies is that part which provides the 20 per cent?

I also discovered that the name comes from the Spanish verb "chupar" meaning to suck, so essentially it means "Sucky Suckers". But who are the suckers here? Certainly not Bernat's company; the Chupa Chups Group now produces four billion lollipops a year which are sold in 40 flavours in 170 countries. And it all goes back to having the courage to kill off weak products and focus development on one good idea.

It seems that the Chupa Chups Group is also enterprising in its means of promotion, at little expense. It deploys tactics to achieve subliminal endorsements at film premieres, music awards and fashion shows, making sure that pop stars, movie stars, and sports icons always have a Chupa Chups to suck once the cameras start rolling. The list of celebrity endorsers is impressive: Madonna, Giorgio Armani, Elton John, Sheryl Crow, Magic Johnson, Jerry Seinfeld, Gerard Depardieu. They have all been recorded as a Chupa Chups "celebrity sucker".

When Johan Cruyff, Barcelona's world-famous soccer coach, gave up smoking, Chupa Chups sent him a box of lollipops. From then on Cruyff could be seen on TV furiously sucking a Chupa Chups as he paced back and forth on the sidelines.

So, back to my quest, the meaning of Chupa Chups for pharmacy. Next time you look at a Chupa Chups stand, think about how it got there, in the most prominent position in your pharmacy. Ask yourself if you want to be the Chupa Chups of the healthcare team. There at the heart of things, with every healthcare commissioner saying "I want that one". Think about how best to achieve those subliminal endorsements and think long and hard about what you need to axe to give the right image in your pharmacy. Who knows, it may even be the Chupa Chups stand! They've served their purpose after all.

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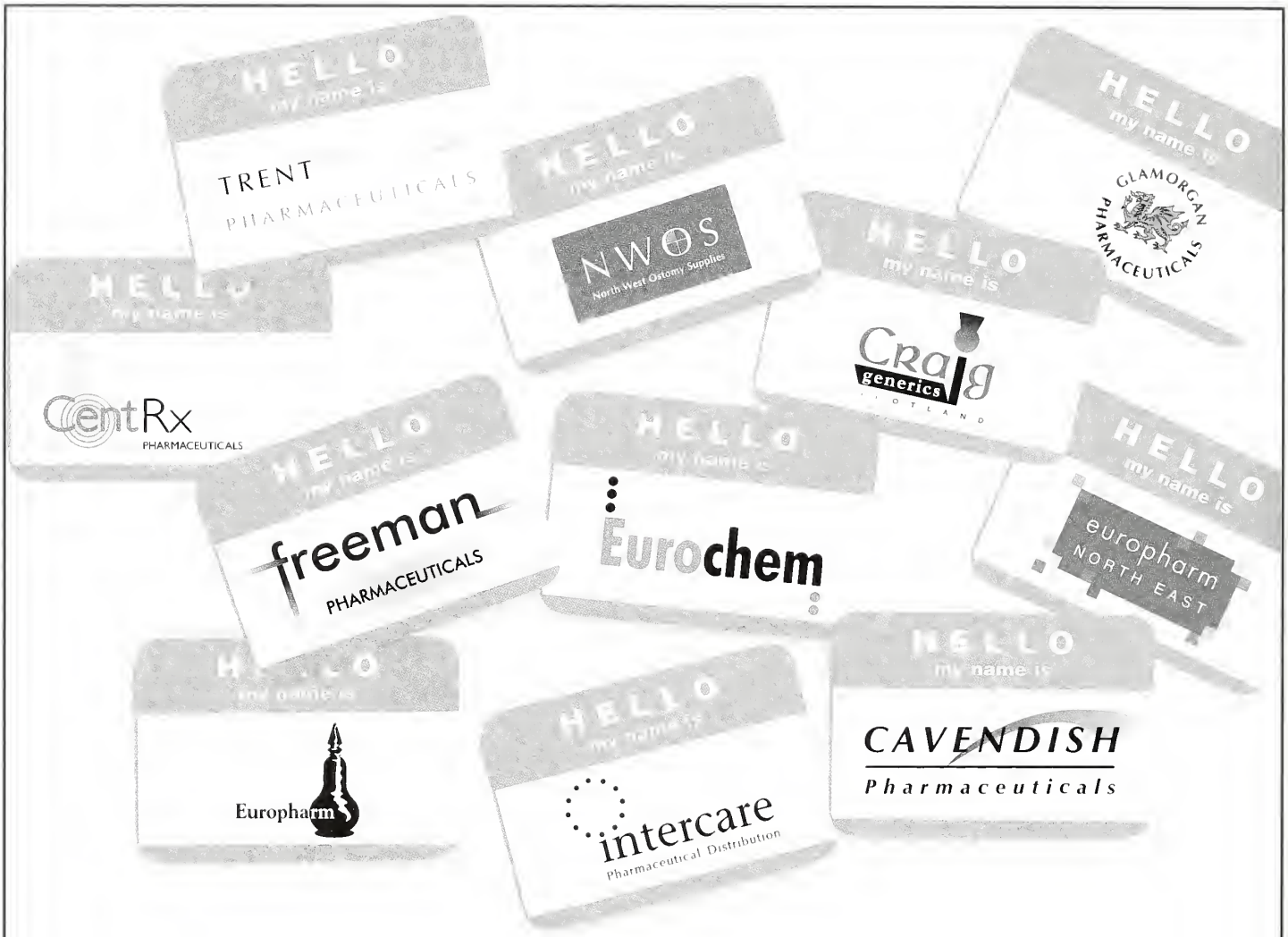

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